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In The

Supreme Court of the United States

October Term, 1992

FHP, INC.,

Petitioner,

v.

ADA SOLORZANO, AMERICA RODRIGUEZ and DOLORES MORALES, in their individual capacities and for the general public,

Respondents.

Petition For Writ Of Certiorari To The California Court Of Appeal, Second Appellate District, Division One

PETITION FOR WRIT OF CERTIORARI

RUSHFELDT, SHELLEY & DRAKE
RANDALL L. SHELLEY
STACY RAPHAEL
12925 Riverside Drive, 4th Floor
Sherman Oaks, California 91423-2287
(213) 872-0811/(818) 906-1141

GREINES, MARTIN, STEIN & RICHLAND
TIMOTHY T. COATES*
9601 Wilshire Boulevard, Suite 544
Beverly Hills, California 90210
(310) 859-7811

* Counsel of Record
Attorneys for Petitioner

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTIONS PRESENTED

1. Does 42 U.S.C. section 1395mm exclusively empowering the Secretary of Health and Human Services and the subordinate agency the Health Care Financing Administration ("HCFA") to contract with health maintenance organizations ("HMOs") to provide care to Medicare beneficiaries, review, regulate and approve all marketing materials and presentations made to Medicare beneficiaries by HMOs and make all determinations as to whether an HMO continues to participate in Medicare and receive federal reimbursement, impliedly preempt a private state court action for injunctive relief under state law (a) seeking to regulate the content and presentation of HMO marketing materials to Medicare beneficiaries and (b) requiring refund of Medicare reimbursement paid to an HMO by the federal government?

2. Where the Secretary of Health and Human Services, through HCFA, conducts an investigation of an HMO's marketing practices with respect to its Medicare plan, concludes there have been no systematic, company-sanctioned violations and finds imposition of significant marketing restrictions or refund of reimbursement neither warranted nor desirable, does the Supremacy Clause bar a private state court action for injunctive relief under state law seeking a conflicting determination as to the propriety of the HMO's marketing practices and entitlement to retain Medicare reimbursement?

LIST OF PARTIES AND RULE 29.4(C) LIST

The parties to the proceeding below were the petitioner FHP, Inc.,[1] erroneously denominated as Family Health Plan, Inc., and respondents Ada Solorzano, America Rodriguez and Dolores Morales, in their individual capacities and for the general public. Under California law, the Los Angeles County Superior Court, as respondent in the underlying writ proceeding in the California Court of Appeal, was also a formal (but non-appearing) party to the appellate proceedings. The California Department of Corporations appeared as amicus curiae on behalf of the plaintiffs.

Because the constitutionality of the exercise of injunctive relief by California state courts has been drawn into question in the instant action, 28 U.S.C. section 2403(b) may be applicable in this case and hence petitioner has served the Attorney General for the State of California with this petition. Neither any of the parties, nor the lower courts, have certified to the Attorney General for the State of California the fact that the constitutionality of the exercise of injunctive relief by California courts in this context has been drawn into question by the instant litigation pursuant to 28 U.S.C. section 2403(b).

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[1] The parent company of FHP, Inc., is FHP International Corporation. Additional subsidiaries include: Great States Financial Corporation; Intercare Benefit Administration, Inc.; Great States Insurance Company; The Hippodrome Gallery Corporation; FHP of New Mexico, Inc.; FHP of Utah, Inc.; Employees Choice Health Option; Health Maintenance Life, Inc.; FHP Reinsurance Limited; FHP Life Insurance Company; and FHP Administrators.

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Petition For Writ Of Certiorari To The California Court Of Appeal, Second Appellate District, Division One

PETITION FOR WRIT OF CERTIORARI

Petitioner FHP, Inc., erroneously denominated herein as Family Health Plan, Inc., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the California Court of Appeal, Second Appellate District, Division One, entered in the above proceeding on November 2, 1992.

OPINIONS BELOW

The opinion of the California Court of Appeal, Second Appellate District, Division One is reported at 10 Cal. App. 4th 1135, 13 Cal. Rptr. 161, and is reprinted in the Appendix, pp. 1 to 22, *infra*. The Court's modification of

the opinion is reported at 11 Cal. App. 4th 443d and reprinted in the Appendix, p. 23, *infra*.

The Minute Order of the Los Angeles County Superior Court that was reversed by the California Court of Appeal was not reported. It is reprinted in the Appendix, pp. 38 to 40, *infra*.

The California Supreme Court's order denying review of the Court of Appeal's opinion was not reported. It is reprinted in the Appendix, p. 41, *infra*.

JURISDICTION

The opinion of the California Court of Appeal, Second Appellate District, Division One, was entered on November 2, 1992. Petitioner timely filed a Petition for Review in the California Supreme Court on Monday, December 14, 1992. California Rules of Court, rule 28(b); *West Pico Furniture Co. v. Superior Court*, 56 Cal. 2d 407, 415, 364 P.2d 295, 15 Cal. Rptr. 119 (1961). On February 11, 1993, the California Supreme Court issued its order summarily denying the Petition for Review. Appendix, p. 41. The remittitur issued from the Court of Appeal on February 25, 1993. The jurisdiction of this Court to review the judgment of the California Court of Appeal, Second Appellate District, Division One, is invoked under 28 U.S.C. section 1257.[2]

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[2] As review of the Court of Appeal decision reveals, the Court squarely addressed the federal preemption issue presented here. Appendix, pp. 1-22, *infra*; *Orr v. Orr*, 440 U.S. 268, 274-275 (1979) [state court's resolution of federal question demonstrates federal question properly raised in proceedings]. Moreover, as required by Supreme Court rule 14.1(h), the Statement of the Case, *infra*, specifies the stages in the proceedings both in the court of first instance and the appellate courts at which the federal question sought to be reviewed was raised.

STATUTES INVOLVED

A. *Article VI, Clause 2, United States Constitution*:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

B. *42 U.S.C. Section 1395.*[3]

C. *42 U.S.C. Section 1395mm(c)(3)(C)-(E).*

D. *42 U.S.C. section 1395mm(i)(3)(A)(i) and (ii).*

E. *42 U.S.C. section 1395mm(i)(6)(B)(i)-(iii).*

F. *42 Code of Federal Regulations 417.223(c)-(d).*

G. *42 Code of Federal Regulations 417.428(a)-(b).*

H. *California Business and Professions Code section 17200.*

I. *California Business and Professions Code section 17203.*

J. *California Business and Professions Code section 17500.*

K. *California Civil Code section 1770.*

L. *California Civil Code section 1780.*

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[3] Pursuant to Supreme Court rule 14.1(f), because the following statutes are lengthy, they are set forth in the Appendix 43-60, *infra*.

STATEMENT OF THE CASE

A. General Overview Of HMO Participation In Medicare[4]

The Medicare program is a federal health insurance program for people 65 or older and certain disabled people. It is administered by the Health Care Financing Administration ("HCFA") of the United States Department of Health and Human Services.

Most Medicare beneficiaries receive medical treatment through the traditional "fee-for-service" delivery system. That is to say, they generally consult a private physician, who renders care to them, and who then forwards a bill to Medicare for payment. Medicare then determines whether it will pay all or a part of the fee charged, based upon a predetermined rate of reimbursement for the particular procedure. If the physician charges more than the Medicare reimbursement rate, the amount in excess of the reimbursement rate would be the responsibility of the patient, unless he or she had separate private "medigap" insurance that would pay for this balance.[5] Moreover, a patient receiving treatment on a

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[4] This summary was provided to the California Court of Appeal pursuant to its request, and is based upon information contained in the Medicare 1992 Handbook, United States Department of Health and Human Services, Health Care Financing Administration, Government Printing Office (1992) and Medicare and Coordinated Care Plans, United States Department of Health and Human Services, Health Care Financing Administration Publication No. HCFA 02195, Government Printing Office (1991).

[5] The practice of billing Medicare beneficiaries for that portion of fees not reimbursed by Medicare is commonly known as "balance billing."

fee-for-service basis is responsible for paying a deductible with respect to most procedures.[6]

There are some services rendered on a fee-for-service basis that are not covered by Medicare at all. For example, routine physical examinations and tests directly related to such examinations (except some pap smears and mammograms), routine foot and dental care, examination for prescribing or fitting eyeglasses or hearing aids, most immunizations, and cosmetic surgery unrelated to an accidental injury, are not subject to payment by Medicare.

A growing segment of the Medicare-eligible population is now electing to forego receiving treatment on a fee-for-service basis and instead obtaining treatment from health maintenance organizations. The chief difference between receiving care from a private physician on a fee-for-service basis and receiving care from an HMO is that in an HMO the patient is essentially charged a basic premium that covers virtually all medical care rendered to him or her while a member of the plan. At the same time, however, this flat fee only covers services rendered by physicians, hospitals or other health care providers, who are either employed by or affiliated with the HMO.[7]

Under 42 U.S.C. section 1395mm, health maintenance organizations may directly contract with the Health Care Financing Administration to provide services to Medicare beneficiaries. Unlike the private physician who bills Medicare directly for each individual procedure performed on a patient, HMOs receive reimbursement from HCFA on a "capitation" basis. That is to say, the HMO is paid a reimbursement rate on a per capita basis, i.e., a flat rate

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[6] For example, for inpatient hospital stays up to 60 days, a Medicare recipient pays a "deductible" of $652. (See Medicare Handbook, pp. 34-35.)

[7] This is commonly referred to as the "lock-in" requirement, since a patient is essentially "locked in" to receiving care from HMO affiliated physicians and facilities.

for each individual enrolled in the plan during a particular period of time.[8]

The federal government strongly encourages Medicare beneficiaries to participate in HMOs, since the government pays only 95% of what it would typically pay to provide the same Medicare services if rendered by individual private physicians on a fee-for-service basis. The government also incurs substantial cost savings through streamlined administration of Medicare reimbursement – it is far simpler to calculate and make reimbursement to an HMO on a capitation basis than it is to process individual reimbursement requests received with respect to services rendered by individual physicians to Medicare beneficiaries.

In addition, Medicare beneficiaries receive significant advantages by receiving Medicare services through an HMO instead of on a fee-for-service basis.[9] First, because the HMO has agreed to accept a flat capitation payment for all Medicare-covered services, HMO beneficiaries do not have to worry about paying a hefty deductible or "balance billing." Nor do they need "medi-gap" insurance. In addition, HMOs provide medical services over and above those subject to reimbursement under the Medicare system, such as preventative care in the form of routine physical examinations, dental care, hearing aids and eyeglasses and, in some instances, prescription drugs.

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[8] This rate is calculated by using an actuarial projection of what Medicare expenses would have been for a given category of Medicare beneficiaries in a given area if care was rendered on a traditional fee-for-service basis. Since health care costs and demographics vary widely from area to area, this base rate may vary depending upon the location of an HMO. Once this rate is set, HCFA pays 95% of the rate to the HMO.

[9] See generally Medicare 1992 Handbook at p. 6; Medicare and Coordinated Care Plans, at pp. 6-7.

While enrolled in an HMO Medicare plan, a Medicare beneficiary, subject to narrow exceptions (i.e., urgent or emergency care), may only receive Medicare-covered care from physicians and other health care providers employed by or affiliated with the HMO. If a Medicare beneficiary receives care from a physician or other health care provider who is not affiliated with the HMO, then the individual patient is liable for those costs – Medicare will generally not pay for those services.[10] A person may disenroll from an HMO Medicare plan at any time, and the disenrollment is effective the first day of the following month. At that point, the individual may receive medical care on a fee-for-service basis from any individual physician or facility and reimbursement is governed by the general fee-for-service Medicare provisions or, the patient may elect to enroll in another HMO Medicare plan.

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[10] If a patient obtains care outside the HMO plan because he or she did not understand that only care received from the HMO would be covered, either Medicare or the HMO may cover the expense, depending upon whether there was a reasonable basis for the patient's belief. HCFA requires contracting HMOs to have a grievance procedure in place to allow Medicare beneficiaries to appeal adverse decisions on coverage. The HMO's disposition of the grievance is, in turn, subject to review by an independent auditor selected by HCFA. The auditor's decision is appealable by the patient through the administrative law system. In general, if a patient's failure to understand the "lock in" provisions of an HMO contract is determined to be attributable to the HMO, then the HMO will be responsible for paying the costs incurred as a result of the patient's consultation with non-HMO physicians or facilities. Under some circumstances, the patient may be "retroactively disenrolled" from the HMO, i.e., the HMO will be required to refund the capitation payment for that enrollee.

B. The Instant Lawsuit and Law and Motion Proceedings.

On or about June 13, 1991, plaintiffs Ada Solorzano, America Rodriguez and Dolores Morales filed a complaint for deceptive practices, unfair competition, untrue or misleading advertising, fraud, and intentional infliction of emotional distress in the superior court of the State of California for the County of Los Angeles. Named as defendants were FHP, Inc., aka Family Health Program, Inc., and various Does. The complaint asserted that the three individual plaintiffs had enrolled in FHP for purposes of receiving Medi-Cal and Medicare benefits based upon various misrepresentations by FHP employees. The complaint sought compensatory and punitive damages and also asserted three claims for injunctive relief under the Deceptive and Misleading Advertising Act and Unfair Practices Act.

On or about October 11, 1991, plaintiffs filed a Motion Compelling Responses to Inspection Demands and for Award of Monetary Sanction, seeking various documents concerning FHP marketing practices as they pertained to *all* enrollees, not simply the named plaintiffs. FHP had objected to the discovery request, arguing that it sought documents that were irrelevant to the individual claims of the three plaintiffs, and that plaintiffs' claims for class-wide injunctive relief were barred by the preemption doctrine and the Supremacy Clause.

On or about October 22, 1991, plaintiffs filed their First Amended Complaint. With the exception of additional allegations concerning the purported ratification of employee misconduct by officers of FHP, the First Amended Complaint was essentially identical to the initial complaint with respect to the causes of action for injunctive relief. It alleged that employees of FHP had misled the three individual plaintiffs into abandoning their private physicians and enrolling in FHP by falsely claiming that plaintiffs could continue to see their own non-FHP physicians with only a nominal charge and that

FHP was part of Medi-Cal. They also alleged that as a part of their FHP contract they agreed to assign FHP their benefits under Medicare and Medi-Cal. Plaintiffs further alleged that these representations were made to other individuals similarly situated and that officers and directors of FHP knew of these alleged misrepresentations by the sales force and were in fact aware that people were disenrolling from the FHP Senior Plan as a result of such misrepresentations.

Under their First Cause of Action under California Civil Code sections 1770 and 1780, plaintiffs requested that FHP be "enjoined from the deceptive practices" alleged in the complaint. The Second Cause of Action under California Business & Professions Code section 17200, predicated upon unfair competition, similarly requested that defendants be "enjoined" from the acts asserted in the First Amended Complaint and additionally prayed for the court to "*restore to the public all funds acquired by means of any act or practice declared by this court to be unlawful or fraudulent or to constitute unfair competition.*" (Emphasis added.) The Third Cause of Action for violation of Business & Professions Code section 17500 sought an injunction preventing defendant from engaging in "untrue or misleading advertising." The Fourth and Fifth Causes of Action, for fraud and intentional infliction of emotional distress asserted claims solely for punitive and compensatory damages.

On November 22, 1991, FHP filed a motion for judgment on the pleadings seeking dismissal of the first three causes of action without leave to amend based upon federal preemption under the Supremacy Clause.[11] FHP concurrently filed a demurrer to the First Amended Complaint which incorporated by reference the arguments raised in its motion for judgment on the pleadings with respect to the first three causes of action.

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[11] FHP also argued for dismissal of the claims for injunctive relief under the state law doctrine of equitable abstention.

On December 30, 1991, FHP filed its opposition to plaintiffs' motion to compel production of documents. FHP reiterated its objection that the balance of plaintiffs' disputed discovery requests were over broad in that they sought information unrelated to the claims of the three individual plaintiffs and that the instant lawsuit could not be maintained as an action for injunctive relief in light of federal preemption. FHP Senior Vice President David Engleberg testified via declaration that he had been contacted by HCFA on December 20, 1991, and been advised that the HCFA investigation into FHP's marketing procedures had concluded that the FHP Senior Plan was in full compliance with HCFA regulations.[12] FHP Director of Membership Laura Baerwolf submitted declaration testimony that supplying plaintiffs with the information they sought as to the over 100,000 members of the FHP Senior Plan would result in a cost of well in excess of $150,000.

On or about December 30, 1991, plaintiffs filed their opposition to the motion for judgment on the pleadings and demurrer.

At the same time, plaintiffs filed their reply to defendant's opposition to the motion to compel responses to inspection demands. Filed in support of the motion to compel was the declaration of Richard W. Grime, Esq., purporting to authenticate an article from the Wall Street Journal which reported that while HCFA had found " 'a number of anecdotal instances of improper sales practices being used by individual sales representatives *there was no confirmation of systematic violations of federal requirements*' " – thus essentially conceding that plaintiffs were attempting to seek injunctive relief on a class-wide basis for system-wide misconduct that HCFA had determined to be non-existent.

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[12] The text of the December 20, 1991, letter from HCFA is set forth in the Appendix, pp. 61-63, *infra*.

On or about January 3, 1992, FHP filed its reply to opposition to the motion for judgment on the pleadings.

On January 7, 1992, the motions came on for hearing before the Honorable Richard Adler in the Los Angeles County Superior Court. The court denied FHP's motion for judgment on the pleadings "without prejudice."[13] Appendix, pp. 36-37.

C. The First Writ Petition

On February 3, 1992, FHP filed a petition for writ of mandate, prohibition and/or other appropriate relief and request for stay in the California Court of Appeal, Second Appellate District (B064462). On April 16, 1992, Division One of that court issued an order to show cause and alternative writ, directing the trial court to vacate its order denying FHP's motion for judgment on the pleadings or to show cause before the court why it should not do so. Appendix, pp. 30-31, *infra*. Plaintiffs then filed a return to the petition. The California Department of Corporations then filed an application to appear as amicus curiae on behalf of the plaintiffs. Prior to oral argument, however, the trial court vacated its original order and on April 29, 1992, entered a new order granting the motion for judgment on the pleadings and dismissing the causes of action for injunctive relief. Appendix, p. 38-39, *infra*. The Court of Appeal dismissed the writ petition as moot. Appendix, p. 33-34, *infra*.

D. The Instant Appellate Proceedings.

Plaintiffs then filed a petition for writ of mandate in the California Court of Appeal seeking review of the trial court's new order dismissing their causes of action for injunctive relief. FHP filed a preliminary opposition and on May 27, 1992, Division One of the Second District

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[13] The court referred the discovery motion to a referee for resolution. It is still pending.

Court of Appeal, noting the importance of the issue presented, issued an order to show cause directing FHP to file opposition and setting the case for oral argument. Appendix, p. 28.

On June 22, 1992, FHP filed its return to the petition for writ of mandate, again arguing that the claims for injunctive relief were preempted under federal law. Plaintiffs filed their reply on or about July 17, 1992. On July 21, 1992, FHP filed a surreply brief confined to addressing the then newly-issued case, *Cipollone v. Liggett Group, Inc.*, 112 S. Ct. 2608 (1992).

On July 23, 1992, the Court of Appeal issued an order requesting the parties to address various questions and submit additional material. Appendix, pp. 26-27.

On August 14, 1992, FHP filed its response to the July 23, 1992, order. On or about August 31, 1992, plaintiffs filed their response to the Court of Appeal's July 23, 1992, order.[14] On September 10, 1992, FHP filed its reply to the response of petitioners and the Department of Corporations to the court's July 23, 1992, order. Following oral argument, on November 2, 1992, the Court of Appeal issued its published opinion granting plaintiffs' writ and directing the trial court to restore plaintiffs' causes of action for injunctive relief, finding there was no federal preemption with respect to such claims. Appendix, p. 1-22, *infra*. On December 1, 1992, the Court of Appeal modified its opinion to correct several textual errors. Appendix, p. 23, *infra*.

On December 14, 1992, FHP, Inc., filed a Petition for Review in the California Supreme Court raising the preemption issue. Appendix, p. 42, *infra*.

On February 11, 1993, the California Supreme Court issued its order denying review. Appendix, p. 41, *infra*.

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[14] The California Department of Corporations also filed a response to the court order.

REASONS WHY CERTIORARI SHOULD BE GRANTED

REVIEW IS WARRANTED BECAUSE CALIFORNIA LAW IMPERMISSIBLY ALLOWS PRIVATE LITIGANTS TO CREATE AN AD HOC REGULATORY SCHEME GOVERNING THE MANNER IN WHICH HMOs SOLICIT, ENROLL AND RECEIVE REIMBURSEMENT FOR PROVIDING SERVICES TO MEDICARE BENEFICIARIES, IN VIOLATION OF 42 U.S.C. SECTION 1395mm AND THE SUPREMACY CLAUSE.

In an effort to control rapidly-spiraling costs for health care to Medicare beneficiaries, Congress in 1982 enacted 42 U.S.C. section 1395mm empowering the Secretary of Health and Human Services to contract with health maintenance organizations to provide care to Medicare beneficiaries. Since that time, the federal government, through the Health Care Financing Administration and associated agencies, has formally and vigorously encouraged Medicare beneficiaries to enroll in HMOs. As a result, in California alone between 1989 and 1991, Medicare HMO enrollment grew at a rate of 20% per year and there are now over 600,000 Medicare beneficiaries in the state enrolled in HMOs. *Monthly Report, Medicare Prepaid Health Plans*, April 1993, Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight, Division of Contract Administration. Nationwide, the rate of Medicare enrollment in HMOs continues to grow, so that the total number of Medicare beneficiaries enrolled in HMOs is well over 1.6 million. *Id.*

This rapid growth and expansion of comprehensive cost efficient medical care to Medicare beneficiaries is made possible in large part because of the streamlined administration of the program – the federal government setting clear and detailed standards governing solicitation, enrollment and provision of services to Medicare beneficiaries – including express review and approval of marketing materials and practices. Payment or refund of

Medicare reimbursement is governed solely by the Secretary through HCFA. Except for incorporation of state licensing requirements for hospitals and physicians, section 1395mm contains no reference to state participation in administration of HMO Medicare contracts or determination of HMO eligibility to receive reimbursement.

Despite the clear provisions of section 1395mm, the California Court of Appeal has, in a published opinion, embraced an extraordinary and unprecedented incursion by private litigants into the manner in which the federal government administers the Medicare program – including decisions with respect to disbursement of federal Medicare funds. Specifically, private litigants have been given license to create via state court injunctive relief, an ad hoc regulatory scheme governing HMO participation in Medicare, including the power to unilaterally determine whether an HMO is entitled to retain or must refund Medicare reimbursement to the federal government. Even more startling, they may do so even where the federal government, after conducting an exhaustive investigation, has expressly found that imposition of further regulations or refund of Medicare reimbursement is neither necessary nor desirable.

The creation of an ad hoc private regulatory system governing the manner in which HMOs participate in Medicare, including their entitlement to retain or refund Medicare reimbursement, flies in the face of clear congressional intention that the Medicare program in general, and HMO participation in particular, be subject to the authority of the federal government. It impairs the substantial federal interest in encouraging HMOs to contract with the federal government to provide services to Medicare beneficiaries, and correspondingly, the federal interest in expanding the number of Medicare beneficiaries who enroll in HMOs and reducing the cost of providing care.

As HMOs stand poised for a rapidly expanding role in providing services to millions of Medicare beneficiaries, the question of precisely who governs HMO participation in Medicare – the federal government or private litigants through state courts – is one of overwhelming federal concern and nationwide importance. For this reason, it is vital that this Court grant review to address the important issues raised herein.

A. Ad Hoc, Unilateral Exercise Of State Court Injunctive Relief By Individual Plaintiffs Conflicts With Exercise Of Federal Power And Stands As An Obstacle To The Federal Interest With Respect To Governing HMO Participation In Medicare.

As this Court noted in *Fidelity Federal Savings & Loan Association v. De la Cuesta*, 458 U.S. 141 (1982), preemption, which has its roots in the Supremacy Clause, is not limited to those instances where Congress has explicitly stated that federal law will supplant state statutes in a given area. Rather, "Congress' intent to supersede state law altogether may be inferred because '[t]he scheme of federal regulation may be so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it,' because 'the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject,' or because 'the object sought to be obtained by federal law and the character of obligations imposed by it may reveal the same purpose.' " *Id.* at 458 U.S. 153. Moreover, as the Court observed: "Even where Congress has not completely displaced state regulation in a specific area, state law is nullified to the extent that it actually conflicts with federal law. Such a conflict arises when 'compliance with both federal and state regulations is a physical impossibility' [citation] or when state law 'stands as an

obstacle to the accomplishment and execution of the full purposes and objectives of Congress [citation]'." *Id.*

The California Court of Appeal concluded preemption would only be appropriate if it was impossible to comply with both state and federal law governing marketing of HMO Medicare plans and that a mere potential for conflict was insufficient to bar exercise of state power. Appendix pp. 18-19, *infra*. The court then observed that there could never be an actual conflict or impairment of federal interest in this context since the federal regulations and the potential exercise of state power by the plaintiffs served a common goal – prevention of fraud. *Id.* at 20, fn. 14. Yet, the Court of Appeal's analysis ignores controlling precedent of this Court.

In *Fidelity Federal Savings & Loan Association v. De la Cuesta*, 458 U.S. 141, the Court struck down California regulations which barred "due on sale" provisions in mortgages issued by federal savings and loan associations. The Court noted that the savings and loan industry was heavily regulated by Congress and that Congress had expressly granted the Federal Home Loan Bank Board the authority to promulgate various regulations, one of which included a provision that a federal savings and loan could, but did not have to, include a due on sale provision in any mortgage. Officials for California argued that since a due on sale provision was only permissive and not mandatory under the federal regulations there was no actual conflict with California law that would justify preemption. The Court disagreed, noting that part of the regulatory process was to allow the board some flexibility in setting requirements and that "limiting the availability of an option the Board considers essential to the economic soundness of the thrift industry, the state has created 'an obstacle to the accomplishment and execution of the full purposes and objectives' of the due on sale regulation." 458 U.S. at 156.

Similarly, in *Jones v. Rath Packing Co.*, 430 U.S. 519, *reh'g denied*, 431 U.S. 925 (1977), the Court struck down a

California labelling statute which created the mere potential for conflict with, and an obstacle to, enforcement of a federal labelling statute. The federal statute required flour labels to disclose the net quantity of the contents within reasonable variations caused by loss or gain of moisture during the course of distribution. The federal regulation recognized that factors during transit, specifically temperature and moisture, could affect the net weight of the product. In contrast, the California regulation made no allowance for loss of weight resulting from moisture loss during the course of distribution. The Court observed that it was conceivable that a flour manufacturer could, under some circumstances, comply with both standards, yet nonetheless noted that the fact that there might be a potential for conflict necessarily meant that the state statute "would prevent 'the accomplishment and execution of the full purposes and objectives of Congress' in passing" the federal regulation in question. 430 U.S. at 543.

In *Franklin National Bank of Franklin Square v. New York*, 347 U.S. 373 (1954), this Court struck down a state court injunction prohibiting a federal savings bank from using the term "savings" in its title based upon a state regulation forbidding such banks from using the term "savings." The Court observed that Congress had empowered federal banks to accept savings deposits and that a state injunction prohibiting advertising of this fact would essentially impair the federal entities in fulfilling their function. 347 U.S. at 377-378.

In each case this Court was careful to observe that under the statutes in question, actual conflict was not inevitable – there might be circumstances in which a party could comply with both state and federal regulations. Preemption was found, however, because the potential for conflict itself and the pervasiveness of the federal interest necessarily meant that potential exercise of state power stood as an obstacle to enforcement of the federal interest. Application of this fundamental principle

mandates a finding of implied preemption with respect to exercise of state court injunctive relief over HMO participation in Medicare.

The actions which form the basis of plaintiffs' causes of action for injunctive relief fall squarely within the province of the Health Care Financing Administration under federal law. Plaintiffs allege various acts of misrepresentation in the course of selling FHP Senior Plans to Medicare beneficiaries. Yet, this is precisely the sort of conduct that Congress has subjected to intense regulation and supervision by HCFA. 42 U.S.C. section 1395mm sets forth the general regulatory scheme by which the federal government sets and makes payments to health maintenance organizations for rendition of Medicare services to members of the public. As review of the statute indicates, the federal government and specifically HCFA, is granted broad power to oversee HMO's who participate in the Medicare program and to intervene in virtually every aspect of their day-to-day operation.

For example, 42 U.S.C. section 1395mm(c)(3)(C) empowers the Secretary to "prescribe the procedures and conditions" under which an HMO solicits and enrolls Medicare beneficiaries in a Medicare-approved plan, and requires the Secretary to review all "brochures, application forms, or other promotional or informational material" prior to issuance, and bar distribution of any that is "materially inaccurate or misleading or otherwise makes a material misrepresentation."

Section 1395mm(c)(3)(D) and (E) similarly set specific standards for providing each enrollee with an explanation of benefits, including restrictions on payments, coverage, etc. The secretary is further granted broad powers to inspect and/or audit any books or records of an HMO that pertain to services it performs for its members pursuant to the Medicare contract. 42 U.S.C. § 1395mm(i)(3)(A)(i) and (ii). At the same time, section 1395mm(i)(6) provides the secretary with broad enforcement power to either terminate the contract of a provider

who is found not in compliance or impose monetary sanctions if an HMO commits various transgressions, including "misrepresents or falsifies information that is furnished – . . . to the secretary . . . or to an individual or any other entity under this section. . . . "[15]

Pursuant to this broad enabling authority, HCFA has, in turn, enacted specific regulations finely detailing the manner in which an HMO such as FHP is to prepare and disseminate sales materials, as well as the manner in which sales are to be conducted. 42 C.F.R. 417.223 and 417.428 provide stringent requirements for submitting sales materials to HCFA for approval and outright prohibit "activities that could mislead or confuse Medicare beneficiaries or misrepresent the organization, its marketing representatives, or HCFA." 42 C.F.R. 417.428(b)(2) (1992); see also 42 C.F.R. 417.223(d)(1) and (2) (1991). These include prohibitions against an organization claiming "that it is recommended or endorsed by HCFA or that HCFA recommends that the beneficiary enroll in the organization," although the regulations permit the HMO to "explain that the entity is approved as an organization for purposes of participation in Medicare." 42 C.F.R. 417.428(b)(2) (1992). Door-to-door solicitation of beneficiaries is prohibited and at all times the HMO must provide any potential enrollee with a full and accurate written explanation of benefits, and verbal sales representations may not materially differ from those contained in the approved written materials. See 417.223(d)(4) (1991); 417.428(b)(1) and (4) (1992).

The extensive nature of these regulations governing virtually every aspect of the solicitation and enrollment of potential Medicare recipients in an HMO make it clear

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[15] The secretary is further empowered to pursue "any other remedies authorized by law" to correct perceived wrongdoing in providing such services to Medicare beneficiaries. 42 U.S.C. § 1395mm(6)(A)(vii).

that there is simply no room for exercise of ad hoc injunctive relief by a state court pursuant to state statutes. As in *De la Cuesta, Franklin National Bank* and *Jones*, the existence of an ad hoc state enforcement scheme creates a potential obstacle to the fulfillment of the regulatory purpose. A federal investigation conducted by HCFA into the marketing practices of an HMO could determine that there was no evidence of company sanctioned misrepresentations and thus permit the HMO, without further restriction, to retain its Medicare contract to provide services to recipients of those federal benefits. At the same time, however, a state court, for whatever reason, might disagree and order injunctive relief essentially requiring specific remedial measures to be taken by the HMO different than those required by the federal government, prevent marketing of the plan altogether or require refund of reimbursement previously paid by the federal government.

Critically, in this case it is obvious that the danger of conflict is no longer abstract, but concrete. As plaintiffs were forced to concede, HCFA *has* completed an investigation to determine whether there were widespread company sanctioned systematic abuses in the manner in which FHP solicited and enrolled Medicare beneficiaries in its Senior Plan in Southern California during the time period covered by plaintiffs' action. While HCFA found some anecdotal evidence of individual misconduct by isolated FHP employees, it found no systematic, company-sanctioned wrongdoing and thus took no action to restrict FHP's continued participation as a Medicare provider. See Appendix, pp. 61-64, *infra*. Nor did it require refund of reimbursement paid during that time period. However, the ad hoc state court injunctive relief which plaintiffs seek would unilaterally impose precisely such restrictions on the manner in which FHP solicits and enrolls Medicare beneficiaries or receives Medicare reimbursement for providing services to such beneficiaries –

and would do so based on the same factual record reviewed by HCFA.[16]

HCFA's pervasive regulation of the manner in which FHP and other HMOs solicit and enroll Medicare beneficiaries leaves no room for unilateral state injunctive relief addressing the same conduct.[17] Thus, plaintiffs argued and the Court of Appeal concluded that exercise of injunctive relief to prevent fraud could not be inconsistent with HCFA regulations, since both the injunctive relief and the regulations have as their purpose the prevention of fraud and abusive sales practices on Medicare beneficiaries. However, this ignores the very conflict that has occurred in this case – a conflict with respect to determining *whether* widespread fraudulent practices are occurring in the first place. While both state and federal authorities might have a joint interest in protecting the

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[16] California Business and Professions Code section 17203 specifically allows injunctive relief based on past conduct. Appendix, pp. 52-53, *infra* [injunctive relief as to person "who engages, has *engaged in*, or proposes to engage in unfair competition . . . "; emphasis added].

[17] In dismissing the "pervasiveness" of federal regulation in this area, the Court of Appeal noted that federal regulations with respect to Medicare reimbursement were far more numerous and detailed than those governing marketing of HMO plans to Medicare beneficiaries, but two federal courts had found the reimbursement regulations insufficient to demonstrate congressional intent to prevent states from prohibiting physicians from balance billing. See Appendix, p. 17, fn. 12, citing *Pennsylvania Medical Society v. Marconis*, 942 F.2d 842 (3d Cir. 1991); *Massachusetts Medical Society v. Dukakis*, 815 F.2d 790 (1st Cir.), *cert. denied*, 484 U.S. 896 (1987). Yet, this is comparing apples to oranges. Any preemption analysis is dependent upon a review of the statutes in question, not some other unrelated set of provisions. The question is whether the provisions of section 1395mm and the applicable federal regulations themselves are pervasive as to marketing of Medicare HMO plans and, more critically, as to payment or refund of Medicare reimbursement.

public against fraudulent practices, to the extent the exercise of state power through an injunction could potentially conflict with a federal statute setting a particular standard for determining whether fraud was occurring with respect to Medicare beneficiaries, that exercise of state power is preempted.

This Court has repeatedly recognized that even if state and federal law have a common goal, there may be preemption where existence and enforcement of the state remedy acts as an obstacle to the federal interest which is contrary to congressional intent. See *Gade v. National Solid Wastes Management Association*, 112 S. Ct. 2374, 2385 (1992) ["In determining whether state law 'stands as an obstacle to the full implementation of a federal law [citation]' it is not enough to say that the ultimate goal of both federal and state law is the same.' [Citation.] 'A state law is also preempted if it interferes with the methods by which the federal statute was designed to reach th[at] goal' "]; *Wisconsin Department of Industry v. Gould, Inc.*, 475 U.S. 282, 291 (1986) [state statute preventing three-time violators of the National Labor Relations Act from doing business with the state preempted even though state law intended to reinforce requirements of the federal law: "The manifest purpose and inevitable effect of the debarment rule is to enforce the requirements of the NLRA. That goal may be laudable, but it assumes for the state of Wisconsin a role Congress reserved exclusively for the board"]; *Michigan Canners and Freezers Association, Inc. v. Agricultural Marketing and Bargaining Board*, 467 U.S. 461, 477 (1984) [state statute creating association to represent agricultural producers preempted even though it and the federal Agricultural Fair Practices Act "share the goal of augmenting the producer's bargaining power"].

The federal government plainly has a substantial interest in encouraging the rendition of services to Medicare beneficiaries in the most efficient and most economical manner – especially in this era of spiraling health care

costs. As a matter of formal policy, it has actively promoted the use of HMOs to achieve those ends. By providing HMOs with a uniform set of standards for marketing such services and coordinating review, approval and enforcement through a single source – HCFA – particularly with respect to the right to receive Medicare reimbursement, the federal government reduces uncertainty and assures resolution of such questions in the most efficient and cost effective means possible. It avoids the duplicative costs that would necessarily attend litigating system-wide compliance issues on an ad hoc basis in state court.

Such concerns are readily apparent in this case where FHP, having already incurred substantial costs in undergoing an exhaustive HCFA investigation, is the subject of a discovery request by plaintiffs that in essence seeks to repeat the HCFA investigation with the attendant costs. Moreover, it is, like all other HMOs, faced with the uncertainty of whether, notwithstanding a marketing plan or procedure's approval by HCFA (or even a state agency with whom HCFA coordinates review and enforcement), it will nonetheless be the subject of a private litigant's claim for injunctive relief, including mandatory refund of Medicare reimbursement received by reason of the practice or procedure.

In addition, there is plainly a substantial and indeed overriding federal interest with respect to the core issue of *whether* an HMO receives Medicare reimbursement. Certainly a state court should not, as plaintiffs and the Court of Appeal would have it do, make a unilateral determination as to whether an HMO such as FHP could continue to receive Medicare reimbursement or be required to refund previous payments made under the Medicare Act. Such state court control of a federal program and, more particularly, federal funds absent express congressional approval, is unprecedented. The federal government has a paramount interest in expenditure of

federal funds for a purely federal program. A clearer invasion of federal interest can scarcely be imagined.

B. The Plain Language And Legislative History Of The Medicare Statutes Support A Finding Of Preemption.

The Court of Appeal erroneously concluded that the entire scheme of Medicare, as well as its legislative history, indicated that Congress intended that there be joint state-federal regulation of Medicare, including the sort of ad hoc regulation by injunction proposed by the individual plaintiffs in the instant action. The court asserted that 42 U.S.C. section 1395 indicated "an intent to minimize federal intrusion into the administration of the Medicare program" (Appendix, p. 17) and that recent amendments to the Secretary's enforcement power, which did not attempt to expressly preempt state regulation, indicated Congressional approval of existing state regulation of HMO marketing practices as they pertain to Medicare beneficiaries. The court also found it significant, but not controlling, that HCFA itself in a manual issued to HMOs participating in the Medicare program stated that participating facilities were required to comply with state and local requirements for marketing activities, "e.g., state licensure and in some states review of marketing material." Appendix pp. 12-13, 18. Review of the federal statutory scheme belies the Court of Appeal's construction.

42 U.S.C. section 1395 simply indicates congressional intent that the actual practice of medicine not be directly controlled by the federal government through the Medicare statutes. Consistent with this, the Medicare statutes in general and those provisions dealing specifically with HMOs expressly delegate to the states determinations as to eligibility of a physician to participate in the Medicare program, i.e., state licensure. See 42 U.S.C. § 1395mm(b)(2)(A)(i). Yet, conspicuously, this is virtually the only reference to state regulation of any aspect of Medicare.

With respect to enforcement provisions governing HMO services to Medicare beneficiaries, two congressional enactments indicate Congress' intention that enforcement of provisions against Medicare providers be the subject of federal, as opposed to state, agency control. First, in 1972, in enacting a provision allowing the Secretary to terminate payments to suppliers of Medicare services in general, the committee report noted that it believed it was important to grant the Secretary broad authority to terminate a physician's participation in Medicare if found guilty of fraud in connection with the furnishing of services to a Medicare beneficiary. Critically, the report observes that the states "can, and some do, bar from *Medicaid* providers who abuse the program, but they are not now required to do so." H. Rep. No. 92-231, 92nd Cong., 2d Sess. (1972), reprinted in 1972 U.S.C.C.A.N., 4989, 5085, emphasis added. Tellingly, the report does not indicate any expectation that a state *could* take any action with respect to fraudulent practices under *Medicare*. Hence, Congress found it necessary to provide the Secretary with clear authority in this regard. See P.L. 92-603, 1972 U.S.C.C.A.N. (86 Stat.) 1646-48 [provisions of the bill].

Second, in 1988, 1395mm(i)(6)(A) was amended to expand the Secretary's authority to take action in the event of fraudulent practices by an HMO, by making the Secretary's enforcement remedies cumulative. The conference report on PL100-360 leaves little doubt that this enforcement authority was intended to be vested solely in the Secretary – there is no reference to any state law remedy. See H. Conf. Rep. No. 100-661, 100th Cong. 2d Sess. (1988), reprinted in 1988 U.S.C.C.A.N. 923, 1025-26.

Nowhere in the Medicare statutes is there *any* reference to a private state civil enforcement action – despite repeated expansion of the Secretary's powers to impose civil remedies. Obviously, had Congress intended to expand state power to private civil enforcement, much

less the sort of ad hoc private regulatory scheme envisioned by plaintiffs through their claims for injunctive relief, it could and would have done so.

Indeed, the only federal statutes remotely authorizing any sort of private action concerning "fraudulent" receipt of federal funds are the general provisions of the False Claims Act, 31 U.S.C. sections 3729 and 3730. In addition to narrowly defining actionable conduct and sharply limiting who may bring a private qui tam action, the statute bars unilateral action by a private litigant in the first instance, requires deference to federal administrative proceedings, gives the government the right to control any litigation, including dismissal or settlement of the action, and places jurisdiction exclusively in the federal courts. 31 U.S.C § 3730. Against this background, it cannot rationally be contended that Congress, in enacting the Medicare statutes in general and the provisions of 42 U.S.C. section 1395mm governing HMO participation in particular, intended to authorize a unilateral private state court action for injunctive relief with respect to the regulatory scheme governing operation of HMOs, or payment of Medicare reimbursement.[18]

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[18] The Court of Appeal asserted that Congress' inaction in the face of state statutes regulating HMO marketing practices in general demonstrates its intention that state injunctive relief by private litigants not be preempted. Appendix, pp. 20-21, *infra*. While Congress might be presumptively aware of general state regulation of HMOs, or even HCFA adoption of, or coordination with, state *government* regulatory actions, it would have no reason to anticipate that general state statutes concerning unfair business practices or fraud might be invoked by individual litigants as a means to unilaterally create a regulatory scheme governing an HMO's participation in Medicare. More significantly, given that no state statute exists purporting to grant a state agency, much less an individual litigant, authority to determine *whether* an HMO receives or must refund Medicare reimbursement, it is illogical to conclude that Congress through its "silence" has tacitly approved a state common law right of

Deliberate congressional inaction in this regard is also underscored by the fact that Congress conspicuously created a joint federal-state enforcement scheme with respect to the *Medicaid* program, itself a program jointly funded and administered by the state and federal governments. That Medicare contains no similar joint enforcement scheme nor any reference to private state civil enforcement of Medicare provisions makes obvious Congress' intention that compliance with Medicare regulations and, most critically, determinations of whether reimbursement will be paid under the Medicare program, would be within the hands of federal regulators.[19]

Moreover, HCFA's statement in its informal guidelines that it expects HMOs to comply with state marketing requirements does not militate against a finding of preemption, especially with respect to the claims for injunctive relief of individual plaintiffs. As a threshold matter, no federal agency has the power to confer independent state jurisdiction in an area that Congress has intended to be occupied by the federal government. Second, and significantly, that HCFA advises HMOs participating in a Medicare contract program that they must also meet state requirements for licensing and for review of marketing materials does not show concurrent jurisdiction but, at most, incorporation of state standards. The power to incorporate state rules is also the power to ignore them. The fact remains that as the statutory scheme and indeed the HCFA manual make clear, it is *HCFA* that dictates the standards for compliance.

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action for injunctive relief with respect to Medicare reimbursement.

[19] Aside from alleging that they received benefits under Medicare, plaintiffs also have alleged that they were eligible for Medicaid. Conspicuously, plaintiffs did *not* allege that the FHP Senior Plan provided services to them under the Medicaid Act or that FHP *received* Medicaid reimbursement from the federal government pursuant to the Medicare contract at issue.

Finally, even assuming HCFA incorporates state agency review of marketing materials or even state licensing requirements of marketing representatives, this does not indicate HCFA deference to the sort of free-wheeling ad hoc claim for injunctive relief that plaintiffs attempt to assert in their civil lawsuit. Whatever utility HCFA might perceive in coordinating review of the marketing materials with *state agencies* applying a given set of standards or even coordinating enforcement actions, quite clearly there is no indication that federal power would yield to the amorphous claims for injunctive relief unilaterally urged by plaintiffs here.

The Court of Appeal ignored the distinction between a state regulatory action with fixed standards subject to coordination with HCFA and the virtually uncontrollable exercise of injunctive relief urged by plaintiffs through a civil lawsuit under general fraud statutes. The court embraced preemption as an all or nothing question – either all state enforcement, either by damage suit or injunction, was preempted, including that of the California Department of Corporations, or nothing was preempted, including plaintiffs' unfettered pursuit of injunctive relief. Appendix, p. 5, n. 2; pp. 15-16. It did so based upon its conclusion that this Court had never taken the identity of parties or the nature of relief sought into account in analyzing preemption issues.

Yet, this Court has routinely drawn a distinction between regulatory actions by state governments and individual civil suits for purposes of preemption. For example, the Court has recognized that enforcement of a state regulatory scheme over an area within the federal sphere may act as an obstacle to the federal interest under circumstances where an individual tort suit by a single plaintiff would not. The former may be preempted, while the latter is permissible. See *English v. General Electric Co.*, 110 S. Ct. 2270, 2278-2279 (1990) [direct state regulation of nuclear power safety preempted, but individual tort claim for infliction of emotional distress permissible

because effect on safety decisions by plant operators "is neither direct nor substantial"]; *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 249-251 (1984) [state tort remedy for injuries from radiation hazard in workplace proper, even though enactment and enforcement of regulations governing safety operations of facilities subject to exclusive federal control].

Moreover, as previously discussed, the greatest obstacle to the federal interest in this case is the fact that these plaintiffs (and presumably others) may act without coordinating their action with HCFA and in complete disregard of HCFA's conclusions regarding precisely the same conduct. Thus, instead of undergoing a single comprehensive administrative investigation by federal or state agencies into marketing practices – an investigation which leads to exoneration in terms of company-wide wrongdoing – an HMO participating in the Medicare program may be subject to after the fact ad hoc and indeed contradictory regulation by unfocused claims for injunctive relief of the sort present here. This multiplies the burden (and corresponding expense to the HMO and the federal government) without producing any concomitant benefit.

Review of the legislative history and plain language of the Medicare statute makes it clear that Congress never intended HMOs participating in Medicare contracts to be subject to ad hoc regulation by injunction in the context of private civil lawsuits. It certainly did not envision that individual plaintiffs, invoking state law concerning unfair business practices or fraud, would have the power to unilaterally dictate to whom federal Medicare reimbursement would be paid.

The question of who has authority over HMO participation in Medicare – the federal government or private litigants through state courts – is of enormous importance and has a "direct and substantial impact" on HMOs weighing the cost and benefits of accepting the federal

government's call to provide high quality, but cost efficient medical care to Medicare beneficiaries. *English v. General Electric Co.*, 110 S. Ct. at 2278. Because private lawsuits for injunctive relief under state law fly in the face of the statutory scheme and stand as an obstacle to enforcement of a substantial federal interest, review is clearly warranted.

CONCLUSION

For the foregoing reasons, petitioner respectfully submits that the Petition for Writ of Certiorari should be granted.

Dated: May 12, 1993.

Respectfully submitted,

RUSHFELDT, SHELLEY & DRAKE
RANDALL L. SHELLEY
STACY RAPHAEL
GREINES, MARTIN, STEIN & RICHLAND
TIMOTHY T. COATES

Attorneys for Petitioner FHP, Inc.

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

ADA SOLORZANO et al., Petitioners, v. SUPERIOR COURT OF LOS ANGELES COUNTY, Respondent; FAMILY HEALTH PLAN, INC., Real Party in Interest.	B067045 (Super.Ct.No. LC009163) (Filed Nov. 2, 1992)

ORIGINAL PROCEEDING; petition for a writ of mandate. Writ granted.

Bet Tzedek Legal Services and Kurt Eggert; Morrison & Foerster, Joseph C. Markowitz, Tamara L. Joseph, and Richard W. Grime, for Petitioners.

Thomas S. Sayles, Commissioner of Corporations, Alan S. Weinger, Supervising Counsel, George A. Crawford, Senior Trial Counsel, and Nicholas Lanza, Corporations Counsel as Amici Curiae on behalf of California Department of Corporations.

No appearance for Respondent.

Rushfeldt, Shelley & Drake, Randall L. Shelley, and Stacy Raphael; Greines, Martin, Stein & Richland and Timothy T. Coates, for Real Party in Interest.

Ada Solorzano, America Rodriguez and Dolores Morales sued Family Health Plan, Inc. (FHP) for damages and injunctive relief, asserting violations of several California statutes arising from FHP's allegedly unfair and misleading advertising practices in soliciting subscribers for its "Senior Plan," a coordinated care plan designed for Medicare beneficiaries. The question before us is whether the federal statute regulating Medicare-qualified health maintenance organizations (HMOs) preempts the field and deprives the states of jurisdiction to grant injunctive relief to these and other individuals dissatisfied with the manner in which an HMO solicits and enrolls Medicare recipients. Our answer is that it does not.

FACTS

Plaintiffs, each of whom receives Medicare and Medi-Cal benefits, were visited at home by FHP's agents, urged to enroll in FHP's Senior Plan, and assured they could continue to be treated by their non-FHP physicians for a "nominal" additional charge. All three plaintiffs enrolled and agreed to assign their Medicare and Medi-Cal benefits to FHP. To their dismay, they discovered that, contrary to the agents' representations, treatment by non-FHP physicians was not covered except for emergency care provided outside FHP's service area and the only

covered services were those offered by FHP's own physicians and affiliated hospitals. They discovered the problem when their own doctors turned them away or billed them in full for noncovered services.

Plaintiffs disenrolled and filed this class action, asking for injunctive relief to stop FHP's alleged unfair competition, deceptive trade practices and deceptive advertising. In addition, Plaintiffs sought general and punitive damages on common law theories of fraud and intentional infliction of emotional distress. FHP demurred to Plaintiffs' first amended complaint, moved to strike the punitive damage claims and moved for judgment on the pleadings against the causes of action seeking injunctive relief. The trial court overruled the demurrer and denied both motions and FHP petitioned for a writ of mandate (*Family Health Plan, Inc. v. Superior Court* (Feb. 3, 1992) B064462) compelling the trial court to grant the motion for judgment on the pleadings on preemption grounds. Although at that stage we were undecided about the merits of FHP's claims, we recognized the need for an early determination of the question and therefore issued an alternative writ which, unfortunately, used the historically correct but currently confusing command to the trial court to either vacate its order denying the motion for judgment on the pleadings or show cause why it should not be ordered to do so.

The trial court took us literally, vacated its order and entered a new order granting the motion. We, in turn, dismissed FHP's petition as moot. Not surprisingly, Plaintiffs then filed this petition for a writ of mandate to compel the trial court to reinstate its original order denying the motion for judgment on the pleadings. This time

we issued an order to show cause instead of an alternative writ.[1]

DISCUSSION

Plaintiffs contend their injunctive relief claims are not preempted by federal law. We agree.

A.

FEDERAL PREEMPTION

Congressional intent, whether explicitly stated or implicitly contained in the structure or purpose of a statute, determines whether a law of the United States preempts regulation by the states of the same subject matter. (*Cipollone v. Liggett Group, Inc.* (1992) 505 U.S. ___ [120 L.Ed.2d 407, 422-423; 112 S.Ct. 2608]; *Jones v. Rath Packing Co.* (1977) 430 U.S. 519, 525.) In the absence of an express congressional command, state law is preempted (1) if it actually conflicts with federal law or (2) if federal law so thoroughly occupies a legislative field by a pervasive and complex regulatory system as to make reasonable the inference that Congress left no room for the states to supplement it. (*Fidelity Federal Sav. & Loan Assn. v. De La Cuesta* (1982) 458 U.S. 141, 153.) Everyone agrees there is no express preemption in this case.

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[1] Contrary to popular belief, we sometimes issue *Palma* notices (*Palma v. U. S. Industrial Fasteners, Inc.* (1984) 36 Cal.3d 171, 180), alternative writs and orders to show cause not because we have made up our minds that the petition ought to be granted but because we perceive a genuine dispute and want to hear the other side of the story.

Where, as here, Congress regulates a field historically within the police powers of the states (public health), the party asserting preemption must establish "that preemption was the 'clear and manifest purpose of Congress.' " (*Pennsylvania Medical Soc. v. Marconis* (3d Cir. 1991) 942 F.2d 842, 846, quoting *Pacific Gas & Elec. v. Energy Resources Comm'n.* (1983) 461 U.S. 190, 206; see also *Perdue v. Crocker National Bank* (1985) 38 Cal.3d 913, 937.) To meet this burden, FHP claims congressional intent to preempt California's regulation of HMO marketing practices is implicit in the Health Care Financing Administration's (HCFA) pervasive regulation of the manner in which HMOs solicit and enroll Medicare-eligible beneficiaries. Alternatively, FHP claims a potential conflict exists between federal regulation of HMO marketing practices and state regulation of the same activities.[2]

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[2] In the trial court and in its initial papers filed here, FHP did not assert preemption as a defense to Plaintiffs' common law damage claims but only to their claims for injunctive relief. While this case was pending, the United States Supreme Court clarified a previously murky issue by holding in *Cipollone v. Liggett Group, Inc., supra,* 505 U.S. ___ [120 L.Ed.2d 407, 112 S.Ct. 2608], that, for purposes of preemption analysis, the phrase "state law" includes common law claims, statutes and regulations. Because we conclude that the federal laws before us do not preclude state regulation of HMOs, it is in any event irrelevant whether Plaintiffs are seeking injunctive relief or damages.

And although FHP originally argued that the statute authorizing appropriations for Medi-Cal (42 U.S.C. § 1396 et seq.) also preempts the field, this position has been abandoned, perhaps because Medi-Cal is a joint state and federal program expressly subject to state regulation. (See, e.g., 42 U.S.C. § 1396b(q)(3).)

B.

MEDICARE AND COORDINATED CARE PLANS

Medicare is a two-part federal health insurance program for people 65 or older and certain disabled people. (42 U.S.C. § 1395 et seq.) Part A helps pay for inpatient hospital care (42 U.S.C. § 1395c et seq.) and Part B helps pay for physicians' services and other outpatient care (42 U.S.C. § 1395j et seq.). Part A benefits are available to most people without payment of a premium but a monthly premium ($31.80 in 1992) is charged for Part B benefits. Both parts have deductibles and coinsurance provisions (noncovered amounts which the benificiary must pay personally or through other insurance).

Most Medicare beneficiaries receive medical care through the traditional "fee-for-service" delivery system. These people consult private physicians and use private hospitals, and bills for services rendered are sent by the healthcare providers to Medicare for payment. Medicare determines whether it will pay all or part of the fee (rates of reimbursement are based on the particular medical procedure and the geographic area in which the services are rendered) and any noncovered balance (including any deductible) is the patient's responsibility.[3] Some services are not covered at all (such as routine physical examinations, eyeglasses, etc.) and are entirely the responsibility

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[3] The practice of billing Medicare beneficiaries for that portion of fees not reimbursed by Medicare is commonly known as "balance billing" and is the subject of regulation in many states. (See *Pennsylvania Medical Soc. v. Macronis, supra,* 942 F.2d 842; *Massachusetts Medical Soc. v. Dukakis* (1st Cir. 1987) 815 F.2d 790.)

of the Medicare beneficiary. Privately purchased "medigap" insurance plans afford coverage for deductibles, copayments and excluded expenses for Medicare beneficiaries using a fee-for-service delivery system.

A growing segment of the population has switched from the fee-for-service system to coordinated care plans – prepaid, managed care plans, most of which are HMOs or competitive medical plans (CMPs).[4] HMOs provide or arrange for all Medicare covered services, generally charging fixed monthly premiums and small copayments and frequently offering benefits not covered by Medicare for little or no additional cost. The major difference between receiving care from a private physician on a pay-as-you-go basis and receiving care from an HMO is that an HMO charges the patient a basic premium covering virtually all medical care rendered by physicians, hospitals and other health care providers employed by or affiliated with the HMO.[5] (See "The Medicare 1992 Handbook," published by HCFA and available through the Consumer Information Center, Department 59, Pueblo, Colorado 81009; see

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[4] Although they are creatures of different statutes and regulations and have distinguishing features (e.g., in the manner in which benefits are delivered, the manner and timing of payments, and the amount of out-of-pocket payments required), HMOs and CMPs are generally referred to in the literature collectively as HMOs. FHP is an HMO, not a CMP but, insofar as we can tell, there are no differences relevant to the preemption issue before us.

[5] This is referred to as a "lock-in" requirement because (subject to exceptions for emergency treatment) the patient is "locked in" to receiving care from HMO affiliated physicians and facilities.

also "Medicare and Coordinated Care Plans," HCFA Publication No. 02195 (1991).)

An HMO may contract with HCFA to provide services to Medicare beneficiaries. Unlike the private physician who bills Medicare directly for each individual procedure performed on each patient, a contracting HMO receives reimbursement from HCFA on a "capitation" basis – in simple terms, this means the HMO's reimbursement rate is calculated on a per capita basis, with a flat rate paid for each individual enrolled in the plan during a particular time period. The rate is calculated by an actuarial projection taking into account the expenses historically paid for a given category of Medicare beneficiaries in a given geographical area on a traditional fee-for-service basis, with the rate varying widely depending upon the location of the HMO. Once the rate is set, HCFA pays 95 percent of the rate to the HMO.[6] It follows that it is to the government's benefit to encourage Medicare beneficiaries to participate in an HMO, since Medicare ends up paying only 95 percent of what it typically would pay for the same services rendered on a fee-for-service basis. Other savings to the government result from the streamlined reimbursement plan and elimination of individual claim processing costs. (See 42 U.S.C. § 1395mm.)

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[6] HMOs are not eleemosynary organizations. Although Medicare patients account for only 33 percent of FHP's enrollees, 62 percent of its 1991 profit came from its contract with HCFA.

C.

THE FEDERAL STATUTES

As noted at the outset, there is no express preemption statement in the Medicare statute. As will now appear, neither is there an implicit expression of Congressional intent to preempt state regulation of marketing efforts directed at Medicare beneficiaries.[7]

In general terms, section 1395 of title 42 of the United States Code prohibits federal interference with the practice of medicine, the manner in which medical services are provided, the hiring practices of institutions and agencies providing health services and the administration and operation of such institutions. (See *Massachusetts Medical Soc. v. Dukakis, supra,* 815 F.2d at p. 791 [construing 42 U.S.C. § 1395 as explicitly stating an intent to minimize federal intrusion into the area of medical services for the elderly and holding that state regulation of

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[7] FHP does not contend the Medicare statute preempts all state regulation of every aspect of the Medicare program. Instead, FHP focuses solely on the conduct condemned by Plaintiffs' complaint and asserts that marketing practices cannot be subjected to state regulation by an "unfocused, ad hoc request for injunctive relief in the sort of civil lawsuit asserted [by these Plaintiffs]." This rather myopic view of the issue incorrectly assumes that the identity of the plaintiff is relevant to the preemption analysis. It is not, and FHP cites no authority suggesting that it is. On the other hand, it is possible for Congress to preempt one area (but not others) of a federally regulated field (*Silkwood v. Kerr-McGee Corp.* (1984) 464 U.S. 238, 249-256; *Pacific Gas & Elec. v. Energy Resources Comm'n., supra,* 461 U.S. at pp. 205, 211-212) and we therefore accept FHP's "marketing practices" limitation of the area at issue in this case.

balance billing is not preempted]; see also *Pennsylvania Medical Soc. v. Marconis, supra,* 942 F.2d at p. 846, fn. 4.)

More specifically, section 1395mm of title 42 of the United States Code addresses the interaction between Medicare and private medical plans, including HMOs, by giving HCFA authority to prescribe procedures and conditions under which an HMO may inform and enroll Medicare beneficiaries. The same section prohibits the distribution of brochures, application forms and other promotional materials to or for eligible individuals unless the materials have been submitted to the Secretary of the Department of Health and Human Resources for review and approval.[8] In the exercise of his discretion, the Secretary must disapprove materials which are materially inaccurate or misleading or which otherwise make a material misrepresentation. (42 U.S.C. § 1395mm(c)(3)(C).) At the time of enrollment and at least annually thereafter, each enrollee must be advised of his or her rights to benefits from the HMO, the restrictions on payments for services furnished other than by or through the HMO, out-of-area coverage provided by the HMO, the coverage available for emergency services and urgently needed care, and appeal rights. (42 U.S.C. § 1395mm(c)(3)(E).)

If HCFA determines that an HMO has misrepresented or falsified information furnished to any individual, the Secretary may provide, "in addition to any other remedies authorized by law," for specified civil money

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[8] HCFA, which is headed by a "Director," operates under the umbrella of the Department of Health and Human Services (HHS), which is headed by a "Secretary." (See 42 C.F.R. § 417.100.)

penalties, for a suspension of the HMO's enrollment of individuals, and for a suspension of payment to the HMO. (42 U.S.C. § 1395mm(i)(6)(A), 7(B).)

D.

THE FEDERAL REGULATIONS

Regulations implementing 42 U.S.C. § 1395mm are set out in Title 42 of the Code of Federal Regulations, section 417.100 et seq., and enrollment procedures are covered by 42 C.F.R. 417.223. Among other things, these regulations require an HMO to provide to interested persons the HMO's rules and regulations regarding membership; an adequate written description of the HMO's basic benefit package and available supplemental benefit packages; the liability of an enrollee for deductible and coinsurance amounts, noncovered services and out-of-plan services; enrollment eligibility and procedures; and such other information (e.g., hours of operation) as may be necessary for the beneficiary to make an informed decision about whether to enroll in the HMO. (42 C.F.R. § 417.223(c)(1).) Subdivision (c)(2) of section 417.223 requires an HMO to submit "all brochures, applications, and promotional and informational material which deal with enrollment of health insurance program beneficiaries with the HMO, to the [HCFA] for approval prior to issuance."

Subdivision (d) of section 417.223 lists proscribed marketing activities. "The HMO may not engage in any of the following activities in marketing its plan to health insurance program beneficiaries: [¶](1) Practices which are discriminatory or unethical in nature; [¶](2) Activities

which would mislead, misinform, confuse, or defraud health insurance program beneficiaries, or misrepresent the HMO, its marketing representatives, or the [HCFA], such as claims that the HMO is recommended or endorsed by the [HCFA] (other than that the organization is approved as an HMO for purposes of participation in the health insurance program . . .), or claims that the [HCFA] recommends that the beneficiary enroll in the HMO or deceptive door-to-door solicitation; [¶](3) Offers of gifts or payment as an inducement to enroll in the HMO (this does not proscribe the explanation of any legitimate benefits the beneficiary might obtain as an HMO enrollee, such as eligibility to enroll in a supplemental benefit plan which covers such items as deductibles and coinsurance, preventive services, etc.); and [¶](4) Promises, claims, or other statements, written or oral, which conflict with, materially alter, or erroneously expand upon the information contained in the marketing materials approved by the Secretary."

E.

THE HMO/CMP MANUAL

The "Health Maintenance Organization/Competitive Medical Plan Manual" is published by HCFA to provide "instructions for implementation of the provisions of Medicare law and regulations particularly as they relate to [HMO] benefits." (Manual, "Forward," § B(1).)[9] Among other things, the Manual covers marketing by

[9] The Manual lodged by the parties was revised most recently in July 1992. It is HCFA Publication No. 75 and is available through the National Technical Information Service of the U.S. Department of Commerce, Springfield, Virginia.

HMOs. After defining "medicare required marketing activities" (open enrollment periods, etc.), and before identifying in detail the permitted and required content of pre-enrollment marketing materials, the Manual explains to the HMOs that "[y]our HMO/CMP member rules cannot conflict with Medicare rules. *You also must meet all State (and local) requirements for marketing activities (e.g., State licensure and in some States, review of marketing material).*" (Manual, § 2201; emphasis added.)

F.

THE STATE STATUTES

1. The Health Care Service Plan Act

Without regard to the identity of enrollees as Medicare recipients or otherwise, California's Department of Corporations regulates HMOs under the Knox-Keene Health Care Service Plan Act of 1975, sections 1340 et seq. of the Health and Safety Code.[10]

The Health Care Service Plan Act is intended, among other things, to ensure that enrollees are informed of

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[10] A "health care service plan" is any person or organization "who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees." (Health & Saf. Code, § 1345, subd. (f).) FHP admits it is a "health care service plan" within the meaning of subdivision (f) of section 1345.

available benefits and services to enable a rational consumer choice in the marketplace and to prevent fraudulent solicitations, deceptive advertising and misrepresentations in the enrollment process. (Health & Saf. Code, § 1342, subds. (b), (c).) To this end, the Act requires that plans be licensed (Health & Saf. Code, § 1349), that they disclose their financial records to the Commissioner of Corporations (Health & Saf. Code, § 1351.1), and that specified fees be paid to cover costs and expenses of administering the Act (Health & Saf. Code, § 1356). Detailed provisions cover persons and firms engaged in the solicitation of enrollees (Health & Saf. Code, § 1359), solicitation materials (Health & Saf. Code, § 1360), advertising (Health & Saf. Code, § 1361) and disclosure forms (Health & Saf. Code, § 1363).[11]

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[11] Definitions are given for written and oral statements that are untrue (Health & Saf. Code, § 1360, subd. (a)(l)), misleading (Health & Saf. Code, § 1360, subd. (a)(2)), and deceptive (Health & Saf. Code, § 1360, subd. (a)(3)). A representation that a plan is sponsored, recommended or approved by the Commissioner of Corporations is prohibited (Health & Saf. Code, § 1360.1) and, subject to limited exceptions, all advertising materials must be filed with the Commissioner prior to distribution (Health & Saf. Code, § 1361). Detailed disclosure statements (benefits, exceptions, limitations, full premium costs, deductibles, copayment requirements, etc.) are required (Health & Saf. Code, § 1363) and deceptive names are prohibited (Health & Saf. Code, § 1366).

The disclosure statement must include a section captioned "Choice of Physicians and Providers" and must include "a description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption 'Liability of Subscriber or Enrollee for Payment' followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice." (Cal. Code Regs., tit. 10, § 1300.63(a)(9).)

By its express terms, the Health Care Service Plan Act applies to plans accepting Medicare beneficiaries as enrollees. (Health & Saf. Code, §§ 1367.12, 1367.15; Cal. Code Regs., tit. 10, §§ 1300.67.50 - 1300.67.55.) Without any exclusions for Medicare-qualified HMOs, the Act permits the Commissioner of Corporations to suspend or revoke a plan's license for a violation of the Act (Health & Saf. Code, § 1386), to sue for civil penalties of up to $2,500 for each violation (Health & Saf. Code, § 1387), to issue cease and desist orders (Health & Safe Code, § 1391), to seek injunctive relief (Health & Saf. Code, § 1392) and to seek involuntary dissolution of the Plan (Health & Saf. Code, §§ 1394.1 – 1394.3). A person who willfully violates the Act is subject to criminal prosecution. (Health & Saf. Code, § 1390.)

Plaintiffs' requests for injunctive relief are not based on the Health Care Service Plan Act and the Act is relevant only insofar as it helps us understand the interaction between the state and federal governments in regulating HMOs. FHP has not attacked the Commissioner of Corporations' right to enforce the Health Care Service Plan Act against FHP (for illegal marketing practices or otherwise) but has, as noted above, limited its attack to a private party's civil suit for injunctive relief. From our perspective, we have a conceptual problem with FHP's position in light of its express admission that it is covered by the Act and its tacit admission that the *Medi-Cal* statute expressly permits state regulation – taken together, these concessions mean the Commissioner of Corporations could seek injunctive relief and civil penalties against FHP for the very conduct complained of by Plaintiffs but that Plaintiffs cannot seek injunctive relief and

can only sue for damages. We reject the temptation to dispose of the issue on this basis and address the preemption issue on the merits.

2. Injunctions Prohibiting Unfair Trade Practices

Plaintiffs' complaint alleges a right to injunctive relief on the basis of three state statutes. The first, section 17200 of the Business and Professions Code, prohibits unlawful, unfair and fraudulent business practices and unfair, deceptive, untrue and misleading advertising. The second, section 17500 of the Business and Professions Code, makes it unlawful for any person or entity to induce someone to enter a contract by disseminating untrue or misleading information. The third, section 1770 of the Civil Code, prohibits deceptive practices in consumer transactions. These statutes are the bases of FHP's assertion that Plaintiffs' "ad hoc" requests for injunctions prohibiting misleading comments about FHP's lock-in provisions are "unfocused."

G.

THE FIELD HAS NOT BEEN PREEMPTED

1. Federal Regulation Is Not Pervasive

Plaintiffs contend the federal statute and regulations are not pervasive and do not sufficiently occupy the field to displace state regulation of FHP's marketing practices. We agree.

As our review of the federal law (parts B, C, D and E, *ante*) reflects, the statute and regulations are neither

extensive nor particularly detailed and there is ample room for the states to fill in gaps in the regulatory scheme. This is true not only with regard to a Medicare-qualified HMO's marketing practices, but to Medicare regulations generally and, for this reason, the courts have consistently rejected arguments that other parts of the federal Medicare regulations are sufficiently pervasive to preclude state regulation. (See, e.g., *Massachusetts Medical Soc. v. Dukakis, supra,* 815 F.2d 790; *Pennsylvania Medical Soc. v. Marconis, supra,* 942 F.2d 842.)[12]

Even if the federal Medicare statute is viewed as "comprehensive," that fact does not persuade in favor of preemption (*Hillsborough County v. Automated Medical Labs., Inc.* (1985) 471 U.S. 707, 717) where, as here, Congress has expressed an intent to minimize federal intrusion into the administration of the Medicare program (42 U.S.C. § 1395) and where, as here, the subject of regulation (public health) is a matter traditionally left to the police powers of the states. (*Pennsylvania Medical Soc. v. Marconis, supra,* 942 F.2d at p. 846; *Massachusetts Medical Soc. v. Dukakis, supra,* 815 F.2d at p. 795 ["a state is ordinarily as concerned as the federal government to see that its elderly citizens enjoy medical care"]; *Pacific Gas &*

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[12] Indeed, the Medicare statute and its ancillary regulations are far more detailed, specific and complex in the area of fees and billing practices than in the area of marketing. At least two courts have nevertheless permitted state regulation of Medicare billing practices, rejecting preemption arguments virtually identical to those asserted by FHP. *Pennsylvania Medical Soc. v. Marconis, supra,* 942 F.2d 842; *Massachusetts Medical Soc. v. Dukakis, supra,* 815 F.2d at pp. 792-794.)

Elec. v. Energy Resources Comm'n., supra, 461 U.S. at p. 206.)

When Congress intends to fully occupy a field to the exclusion of state regulation, it knows how to do so. (*Jones v. Rath Packing Co., supra,* 430 U.S. at pp. 530-532; *Rice v. Santa Fe Elevator Corp.* (1947) 331 U.S. 218, 230-236.) That is not what it did here and it is clear that preemption of marketing practices was not intended. As HCFA explains in its HMO/CMP Manual (see fn. 9, *ante*), an HMO soliciting Medicare beneficiaries must meet all state and local requirements for marketing activities. HCFA has construed the federal law in the only logical fashion – against preemption and in favor of joint regulation with the states, to ensure that the elderly and infirm are not victimized by deceptive advertising practices. The Department of Corporations shares this view and has filed an amicus brief asserting its right to regulate FHP under the Health Care Service Plan Act (Health & Saf. Code, § 1340 et seq.) and providing examples of enforcement actions it has pursued against other Medicare-qualified health care plans without objection on preemption grounds. While we do not find persuasive another HMO's failure to raise the preemption issue, we do consider it significant that both HCFA and the state interpret the federal statute to permit state regulation. (*Mudd v. McColgan* (1947) 30 Cal.2d 463, 470.)

2. Federal Law Does Not Conflict With State Law

FHP contends state court injunctive relief potentially conflicts with federal regulation of an HMO's marketing practices because California *might* impose a penalty

greater than any of those available under the federal regulations. We disagree.

First, a state's imposition of a stiffer penalty or a higher standard of care than mandated by federal law does not preclude state regulation. (*California v. ARC America Corp.* (1989) 490 U.S. 93, 105 ["state causes of action are not preempted solely because they impose liability over and above that authorized by federal law"]; *Silkwood v. Kerr McGee Corp., supra,* 464 U.S. at pp. 257-258 [punitive damage award 10 times greater than allowable federal fine upheld against federally licensed nuclear plant operator].) Second, the conflict requiring preemption is a conflict between state and federal law which arises when "compliance with both federal and state regulations is a physical impossibility' (*Florida Avocado Growers v. Paul* (1963) 373 U.S. 132, 142-143; see also *Hillsborough County v. Automated Medical Labs., Inc., supra,* 471 U.S. at pp. 715-716) or when state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress" (*Hines v. Davidowitz* (1941) 312 U.S. 52, 67).[13] Neither condition is present here and mere speculation about a hypothetical conflict is not the stuff of which preemption is made. (*Younger v. Jensen* (1980) 26 Cal.3d 397, 408-409; *Exxon Corp. v. Governor of Maryland* (1978) 437 U.S. 117, 130-131.).

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[13] In each of the cases relied upon by FHP, simultaneous compliance with state and federal regulations was a physical impossibility. (*Fidelity Federal Sav. & Loan Assn. v. De La Cuesta, supra,* 458 U.S. 141; *Jones v. Rath Packing Co., supra,* 430 U.S. 519; *Franklin Nat. Bank v. New York* (1954) 347 U.S. 373.)

Our review of the federal statute, regulations and operating manual on the one hand, and of Plaintiffs' complaint and the California statutes and regulations on the other, reveals no conflict, present or potential. Indeed, the federal and state regulatory schemes are strikingly similar, consistently parallel systems working together to prevent the very practices Plaintiffs allege – misrepresentations about the lock-in provisions of FHP's Senior Plan.[14]

3. Congress Did Not Intend To Preempt The Field

Another persuasive argument against preemption is the fact that, at the time of the most recent (1990) amendments to the Medicare marketing statute (42 U.S.C. § 1395mm(i)(6)(A) [the penalty provision]), Congress presumably was aware of the fact that some states (including California) had statutes restricting the marketing practice

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[14] We cannot take seriously FHP's claim that an injunction might prevent the continued marketing of its Senior Plan in its present form. To justify an injunction restraining sales of that plan, the trial court would have to be satisfied that the plan itself was misleading, deceptive or otherwise prohibited. If it is, it should be enjoined. If it isn't, it won't be.

Relying on *Diaz v. Kay-Dix Ranch* (1970) 9 Cal.App.3d 588 and *People ex rel. Dept. of Transportation v. Naegele Outdoor Advertising Co.* (1985) 38 Cal.3d 509, FHP also contends the mere existence of a federal regulatory scheme makes state injunctive relief inappropriate under general principles of equity. The cases are inapposite because, unlike the case at bench, both deal with fields absolutely and entirely preempted by federal law (immigration and Indian affairs).

of HMOs.[15] Congress nevertheless did not include a specific preemption provision in the 1990 amendment to 42 U.S.C. § 1395mm. As the Supreme Court explained in *California Federal Sav. & Loan Assn. v. Guerra* (1987) 479 U.S. 272, 287-288, when Congress remains silent regarding the preemptive effect of its legislation on state laws it knows to exist at the time it passes such legislation, Congress has failed to express an intent to supersede those state laws. (See also *Pennsylvania Medical Soc. v. Marconis, supra,* 942 F.2d at p. 850.)

DISPOSITION

Congress clearly recognized the need for state and local assistance in regulating the marketing of HMOs and other supplemental health care packages to the elderly and disabled and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the help it can get. Accordingly, Plaintiffs' petition for writ of mandate is granted. Let a writ issue directing the trial court to vacate its May 29, 1992, order granting FHP's motion for judgment on the pleadings and to reinstate its order of January 7, 1992, overruling FHP's demurrer to the first amended complaint and denying FHP's motion for judgment on the pleadings.

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[15] California's Health Care Service Plan Act was enacted in 1975. (Stats. 1975, ch. 941, § 2, p. 2071.)

CERTIFIED FOR PUBLICATION.

VOGEL, J.

We concur:

SPENCER, P.J. ORTEGA, J.

CERTIFIED FOR PUBLICATION

ADA SOLORZANO et al., Petitioners v. SUPERIOR COURT OF LOS ANGELES COUNTY, Respondent; FAMILY HEALTH PLAN, INC., Real Party in Interest.	B067045 (Super.Ct.No. LC009163) ORDER MODIFYING OPINION (Filed Dec. 1, 1992)

THE COURT:*

In response to the Plaintiffs' request for modification of the opinion and for costs on appeal.

1. On page 3 of the slip opinion, on the first line of the first full paragraph, the word "class" is deleted, so that the first phrase of the first sentence reads: "Plaintiffs disenrolled and filed this action, . . . "

2. On page 24 of the slip opinion, under the heading "DISPOSITION," the date in the eighth line is changed from May 29, 1992, to April 29, 1992.

Plaintiffs' request for an award of "costs on appeal" is denied. (See Eisenberg, Horvitz & Weiner, Cal. Prac. Guide: Civil Appeals & Writs (Rutter 1992) § 15:242, p. 15-50.3.)

This modification does not affect the judgment.

*VOGEL, J. SPENCER, P.J. ORTEGA, J.

COURT OF APPEAL OF THE SATE OF CALIFORNIA
FOR THE SECOND APPELLATE DISTRICT
DIVISION: 1

Greines, Martin, Stein & Richland
Timothy T. Coates
9601 Wilshire Blvd.
Ste. 544
Beverly Hills, CA. 90210 5215

RE: Solorzano, Ada
vs.
S.c.l.a.
Family Health Plan, Inc.
2 Civil B067045
Los Angeles NO. LC009163

* * REMITTITUR NOTICE * *

Notice is hereby given that the Remittitur has been issued this date and that the opinion, decision or order entered in the above entitled cause on 11/02/92 is now final.

* * Petition Granted By Opinion. * *

JOSEPH A. LANE, Clerk
By: G. Mercier
Deputy Clerk

FEB 25 1993

(SEAL)
OFFICE OF THE CLERK
COURT OF APPEAL
STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
JOSEPH A. LANE, CLERK

July 23, 1992

DANIEL P. POTTER
Chief Deputy

Second Floor, North Tower
300 South Spring Street
Los Angeles, California 90013
Telephone: (213) 897-2307

Morrison & Foerster
Joseph C. Markowitz, Esq.
Tamara L. Joseph, Esq.
Richard W. Grime, Esq.
555 West Fifth Street
Suite 3500
Los Angeles, CA

Greines, Martin, Stein & Richland
Timothy T. Coates, Esq.
9601 Wilshire Boulevard
Suite 544
Beverly Hills, CA 90210

Rushfeldt, Shelley & Drake
Stacy Raphael, Esq.
12925 Riverside Drive
4th Floor
Sherman Oaks, CA 90210

Bet Tzedek Legal Services
Kurt Eggert, Esq.
145 South Fairfax Avenue
Suite 200
Los Angeles, CA 90036

California Department of Corporations
Thomas S. Sayles, Commissioner
Alan S. Weinger, Esq.
George A. Crawford, Esq.
Nicholas Lanza, Esq.
3700 Wilshire Blvd., Suite 600
Los Angeles, CA 90010

Dear Counsel:

RE: *SOLORZANO et al. v. SUPERIOR COURT – B067045*

Oral argument is continued to September 22, 1992. In the interim, the court requests submission of the following additional information by FHP (and response by Plaintiffs and amicus as provided below):

1. Various materials refer to the HCFA's "guidelines" to HMOs (something other than the regulations). Are these published? If so, where? If not, please lodge a copy with the Court and serve a copy on Plaintiffs.

2. Is FHP a "health care service plan" within the meaning of subdivision (f) of section 1345 of the Health and Safety Code? If not, why not? If it is, is it subject to the standards of section 1359 et seq. of the same Code? If so, is it FHP's position that enforcement of sections 1359, 1360 and 1361 of the Health and Safety Code is preempted by 42 U.S.C. § 1395mm insofar as solicitations to Medicare recipients are concerned?

3. Do you have access to any legislative history materials on 42 U.S.C. § 1395mm or 42 C.F.R. §§ 417.223, 417.28, or related statutes or regulations? If so, please lodge copies with the court and serve copies on Plaintiffs.

4. In plain English, please explain the basic relationship between HMOs and Medicare, the intended benefit to Medicare recipients enrolling in HMOs, and anything else you wish to include to clarify the context in which the preemption issue is before the court.

FHP's submission shall be filed and served on or before August 14, 1992. Responses by Plaintiffs and

Amicus Curiae Department of Corporations, if any, shall be filed and served on or before August 31, 1992. FHP may file a reply on or before September 10, 1992.

Very truly yours,
/s/ Victor Salas
Victor Salas
Deputy Clerk

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

ADA SOLORZANO et al., Petitioners, v. THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, Respondent, FAMILY HEALTH PLAN, INC., Real Party in Interest.	B067045 (L.A.S.C. No. LC009163) (RICHARD ADLER, Judge) ORDER TO SHOW CAUSE

It appearing that a novel and important issue of law has been presented, you are hereby ordered to:

SHOW CAUSE before this court in its courtroom at 300 South Spring Street, Third Floor, Los Angeles California, on July 29, 1992, at 9:00a.m., why a peremptory writ should not issue, granting the relief requested in the petition.

The written return in opposition to the writ is to be served and filed on or before June 22, 1992.

By order of this court.

ATTEST my hand and the seal of this court this 27th day of May, 1992.

JOSEPH LANE, Clerk
By /s/ G. Mercier
Deputy Clerk

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

FAMILY HEALTH PLAN, INC., Petitioner, v. THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, Respondent, ADA SOLORZANO et al., Real Parties in Interest.	B064462 (L.A.S.C. No. LC009163) (RICHARD ADLER, Judge) ALTERNATIVE WRIT OF MANDATE

TO THE SUPERIOR COURT OF THE STATE OF CALIFORNIA,
FOR THE COUNTY OF LOS ANGELES:

Good cause appearing therefore, you are hereby required either to:

(a) vacate the order in Los Angeles County Superior Court case No. LC009163, entitled Ada Solorzano et al. v. Family Health Plan, Inc., et al., denying petitioner's motion for judgment on the pleadings without prejudice and overruling its demurrer to three causes of action of the first amended complaint, and thereafter make a new and different order granting said motion and sustaining said demurrer, or

(b) in the alternative

SHOW CAUSE before this court in its courtroom at 300 South Spring Street, third Floor, Los Angeles, California, on May 27, 1992, at 9:00a.m., why a peremptory writ of mandate ordering you to do so should not issue.

If respondent court chooses to comply with alternative (a), then a certified copy of the minute order showing compliance shall be filled with this court on or before, the date that the return is due.

The written return in opposition to the writ is to be served and filed on or before April 29, 1992.

WITNESS THE HONORABLE JUSTICE SPENCER, Presiding Justice of Division One of the Court of Appeal of the State of California, Second Appellate District.

ATTEST my hand and the seal of this court this 16th day of April, 1992.

JOSEPH LANE, Clerk
By /s/ Victor I. Salas
Deputy Clerk

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

FAMILY HEALTH PLAN, INC., Petitioner, v. THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, Respondent, ADA SOLORZANO et al., Real Parties in Interest.	B064462 (L.A.S.C. No. LC009163) (RICHARD ADLER, Judge) ORDER (Filed April 16, 1992)

THE COURT*:

In order to give the court the opportunity to review the petition for writ of mandate, filed February 10, 1992, it is hereby ordered that all further discovery be stayed pending determination of the within petition or further order of this court.

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION ONE

FAMILY HEALTH PLAN, INC., Petitioner, v. THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, Respondent, ADA SOLORZANO, AMERICA RODRIGUEZ, and DOLORES MORALES, in their individual capacities and for the general public, Real Parties in Interest.	B064462 (L.A.S.C. No. LC009163) (RICHARD ADLER, Judge) ORDER DISCHARGING ALTERNATIVE WRIT AND DISMISSING PETITION (Filed May 6, 1992)

THE COURT*:

This court, having issued its Alternative Writ on April 16, 1992, directing respondent to either (a) vacate its order denying petitioner's motion for judgment on the pleadings without prejudice and overruling its demurrer to three causes of action of the first amended complaint, and thereafter make a new and different order granting said motion and sustaining said demurrer, or (b) show cause why a peremptory writ should not issue commanding it to do so; and it appearing from a certified copy of its minute order of April 29, 1992, that respondent has

fully complied with alternative (a) of the writ, thereby rendering this original proceeding moot,

IT IS HEREBY ORDERED that the alternative writ is discharged; the temporary stay order, issued April 16, 1992, is terminated; and the petition is dismissed as moot.

*DEVICH, Acting P.J. ORTEGA, J. VOGEL, J.

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

DEPT.
NW Z

DATE JANUARY ~~15~~ 7, 1992

HONORABLE ~~DAVID HOROWITZ~~ JUDGE

*Richard Adler**

HONORABLE JUDGE PRO TEM

NONE Deputy Sheriff

DEPUTY CLERK _____
P. TINNELL

_____

M. Sanders
~~L. FENNER~~

Reporter
(Parties and counsel checked if present)

LC 9163
ADA SOLORZANO, AMERICA RODRIGUEZ, DOLORES MORALES

VS.

FHP, INC. ET AL.

Counsel for Plaintiff *J.C. Markowitz*
R.W. Grime

Counsel for Defendant *T.T. Coates*
RUSHFELDT, SHELLEY & DRAKE
by S.L. Raphael and Randall Shelley

---

* Italics were handwritten in original.

NATURE OF PROCEEDINGS.

1. DEFENDANT FHP, INC. MOTION TO STRIKE PORTIONS OF FIRST AMENDED COMPLAINT.
2. DEFENDANTS MOTION FOR JUDGMENT ON THE PLEADINGS.
3. DEFENDANT FHP, INC. DEMURRER TO FIRST AMENDED COMPLAINT.
4. PLAINTIFFS ADA SOLARZANO, AMERICA RODRIGUEZ, AND DOLORES MORALES, IN THEIR INDIVIDUAL CAPACITIES AND FOR THE GENERAL PUBLIC, MOTION COMPELLING RESPONSES TO INSPECTION DEMANDS AND FOR AWARD OF MONETARY SANCTION.

1. *Motion is denied.*

4. Court finds that it is necessary to appoint a referee to hear and determine any and all discovery motions and disputes in this matter. Accordingly, pursuant to CCP 639(a) and CCP 645.1, the Court hereby appoints *William F. Powers (Devonshire Professional Building, 20933 Devonshire Street, Suite 102, Chatsworth, Ca. 91311 (818) 773-4800),* to serve as referee and to hear and determine all pending and future discovery motions and disputes.

The referee shall notify the parties as to the amount of his estimated fees, and, unless the referee shall otherwise direct, each side shall advance it's share of the fees. The referee is empowered to recommend sanctions and reallocate the reference fees.

ILLEGIBLE ---------- IN DEPT. ----------

[ ] On court's own motion

[ ] REQUEST OF

[ ] TRO to remain in full force and effect

[ ] Stip. to be filed

[ ] Moving party

[ ] On oral/written stipulation

[ ] Respondent(s)

[ ] TRO dissolved

[ ] OSC Discharged

[ ] Per Ex Parte Order of _____

2. [x] MOTION: [ ] granted as prayed [x] denied *without prejudice* [ ] argued and taken under submission

3. [x] DEMURRER [ ] sustained [x] overruled [ ] with/without leave to amend [ ] _____ days to amend/answer

[ ] JUDGMENT [ ] ORDER TO BE PREPARED BY: [ ] Moving party [ ] Responding party [ ] Clerk

[x] NOTICE: [ ] Waived [x] By moving party [ ] By respondent(s)

[ ] PETITIONER(S) IS/ARE SWORN AND TESTIFIES/TESTIFY

[ ] PETITION IS GRANTED (AS AMENDED)

[ ] DECREE IS SIGNED AND FILED.

MINUTES ENTERED
~~1/15/92~~ *1-7-92*
COUNTY CLERK 582
DEPT. NW Z

DEPT. NWY

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

Date 4-29-92

HONORABLE RICHARD ADLER JUDGE

NONE Deputy Sheriff

#1 Court Attendant

L. LOTT , Deputy Clerk

NONE , Reporter

(Parties and counsel checked if present)

LC 9163

ADA SOLORZANO, ETC., ET AL

VS.

FHP, INC., ETC.

Counsel for Plaintiff

Counsel for Defendant

NATURE OF PROCEEDINGS:

1) COURT'S RULING IN RESPONSE TO THE COURT OF APPEAL "ALTERNATIVE WRIT OF MANDATE"

2) COURT VACATES ORDER OF APRIL 17, 1992

Pursuant to the Court of Appeal "Alternative Writ of Mandate" filed April 16, 1992 the court makes the following order:

1) The order of January 7, 1992 denying without prejudice the Motion for Judgment on

the Pleadings and overruling the demurrer of defendant FHP, Inc. is vacated.

2) Defendant FHP's Motion for Judgment on the Pleadings is granted and the Demurrer as to the three causes of action of the First Amended Complaint is sustained without leave to amend.

Further, the court vacates all orders made on April 17, 1992 and all further motions are to be filed in the Law and Motion court.

A certified copy of this minute order is mailed this date by the court clerk to:

1) Joseph C. Markowitz, Esq., MORRISION & FOERSTER, 555 West Fifth Street, Suite 3500, Los Angeles, Ca 90013-1024

2) Randall L. Shelley, Esq., RUSHFELDT, SHELLEY & DRAKE, 12925 Riverside Drive. Fourth Floor, Sherman Oaks, CA 91423-2287

3) Kurt Eggert, Esq., BET TZEDEK LEGAL SERVICES, 145 Fairfax Avenue, Suite 200, Los Angeles, Ca 90036

4) Timothy T. Coates, Esq., GREINES, MARTIN, STEIN & RICHLAND, 9601 Wilshire Blvd., Suite 544, Beverly Hills, CA 90210

5) William Powers, Jr., Esq., 20933 Devonshire Street, Suite 102, Chatsworth, CA 91311

6) California Court of Appeal, SECOND APPELLATE DISTRICT, DIVISION ONE, 300 S. Spring Street, Floor 2, N. Tower, Los Angeles, CA 90013

THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED IS A FULL, TRUE AND CORRECT COPY OF

THE ORIGINAL ON FILE AND OF RECORD IN MY OFFICE,
ATTEST 4-29- 1992
JAMES H. DEMPSEY, Executive Officer/Clerk
of the Superior Court of California,
County of Los Angeles.
By /s/ L. Lott, Deputy
L. LOTT

MINUTES ENTERED

4-29-92
COUNTY CLERK
DEPT. NWY

Second Appellate District, Division One,
No. B067045 S030224

IN THE SUPREME COURT OF THE
STATE OF CALIFORNIA

IN BANK
(Filed Feb. 11, 1993)

ADA SOLORZANO Et Al., Petitioners

v.

LOS ANGELES COUNTY SUPERIOR COURT,
Respondent

FAMILY HEALTH PLAN INC., Real Party In Interest

Real Party In Interest's petition for review DENIED.

/s/ LUCAS
Chief Justice

S _____

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

ADA SOLORZANO, et al., Petitioners, v. SUPERIOR COURT OF LOS ANGELES COUNTY, Respondent. FAMILY HEALTH PLAN, INC., Real Party In Interest.	2d Civil No. B067045 (Los Angles County Superior Court Case No. LC 009163, Honorable Richard Adler, Judge)

ISSUES PRESENTED

1. Where 42 U.S.C. section 1395mm expressly delegates to the Secretary of Health and Human Services and the subordinate agency the Health Care Financing Administration ("HCFA") the duty to review, regulate and approve all marketing materials and presentations made to Medicare beneficiaries by health maintenance organization ("HMOs") contracting with the federal government to provide care to Medicare beneficiaries and to make all determinations as to whether a health care maintenance organization continues to participate in Medicare and receive federal reimbursement, does the Supremacy Clause of the United States Constitution bar a state court action for injunctive relief under state law, seeking to regulate the content and presentation of HMO marketing materials to Medicare beneficiaries and refund of Medicare reimbursement paid by the federal government?

42 USC § 1395

§ 1395. Prohibition against any Federal interference

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

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42 USC § 1395mm(c)(3)(C)(D)(E)

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all

such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(D) The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of –

(i) the enrollee's rights to benefits from the organization,

(ii) the restrictions on payments under this subchapter for services furnished other than by or through the organization,

(iii) out-of-area coverage provided by the organization,

(iv) the organization's coverage of emergency services and urgently needed care, and

(v) appeal rights of enrollees.

* * *

42 USC § 1395mm(i)(3)(A)(i) and (ii)

(3) Each contract under this section –

(A) shall provide that the Secretary, or any person or organization designated by him –

(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

* * *

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42 USC § 1395mm(i)(6)(A)-(B)

(6)(A) If the Secretary determines that an eligible organization with a contract under this section –

(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(v) misrepresents or falsifies information that is furnished –

(I) to the Secretary under this section, or

(II) to an individual or to any other entity under this section;

(vi) fails to comply with the requirements of subsection (g)(6)(A) or paragraph (8) of this section; or

(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this subchapter under section 1320a-7 or 1320a-7a of this title for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are –

(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,

(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

* * *

42 CFR 417.223(c)-(d)

§ 417.223 Enrollment procedures.

(c) *Required marketing activities.* In offering its plan to health insurance program beneficiaries, the HMO shall:

(1) Provide health insurance program beneficiaries who express interest in applying for membership with the HMO's rules and regulations regarding membership and an adequate written description of:

(i) The HMO's basic benefit package for health insurance program beneficiaries and any supplemental benefit packages that are available, including the amounts of the premiums, if any, for such benefit packages;

(ii) The liability of an enrollee who is a health insurance program beneficiary, for deductible and coinsurance amounts, noncovered services, and out-of-plan services;

(iii) Enrollment eligibility and procedures; and

(iv) Such other information including hours of operation, clinic locations, and directions for obtaining service, as may be necessary in order for the beneficiary to make an informed decision on whether to enroll in the HMO;

(2) Submit all brochures, applications, and promotional and informational material which deal with enrollment of health insurance program beneficiaries with the HMO, to the Health Care Financing Administration for approval prior to issuance; (The HMO shall be notified, within 30 days of the receipt of such materials by the

Health Care Financing Administration, as to whether they have been approved or disapproved by the Health Care Financing Administration.); and

(3) Notify the general public of its enrollment periods, whether they are for a limited duration or continuous, in an appropriate manner in appropriate media throughout its enrollment area.

(d) *Proscribed marketing activities.* The HMO may not engage in any of the following activities in marketing its plan to health insurance program beneficiaries:

(1) Practices which are discriminatory or unethical in nature;

(2) Activities which would mislead, misinform, confuse, or defraud health insurance program beneficiaries, or misrepresent the HMO, its marketing representatives, or the Health Care Financing Administration, such as claims that the HMO is recommended or endorsed by the Health Care Financing Administration (other than that the organization is approved as an HMO for purposes of participation in the health insurance program, and that the organization is qualified as an HMO under the Health Maintenance Organization Act of 1973 (Pub. L. 93-222) or under title XIX of the Social Security Act, where appropriate), or claims that the Health Care Financing Administration recommends that the beneficiary enroll in the HMO or deceptive door-to-door solicitation;

(3) Offers of gifts or payment as an inducement to enroll in the HMO (this does not proscribe the explanation of any legitimate benefits the beneficiary might obtain as an HMO enrollee, such as eligibility to enroll in

a supplemental benefit plan which covers such items as deductibles and coinsurance, preventive services, etc.); and

(4) Promises, claims, or other statements, written or oral, which conflict with, materially alter, or erroneously expand upon the information contained in the marketing materials approved by the Secretary.

* * *

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42 CFR 417.428(a)-(b)

§ 417.428 Marketing activities.

(a) *Required marketing activities.* An organization must meet the following requirements.

(1) Offer its plan to Medicare beneficiaries and provide to those interested in enrolling, adequate, written descriptions of the organization's rules, procedures, benefits, fees and other charges, services, and other information necessary for beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time limited or continuous) in an appropriate manner through appropriate media, throughout its enrollment area.

(3) Submit all marketing materials to HCFA at least 45 days before their planned distribution.

(4) Include in the organization's written materials provided to prospective enrollees prior to enrollment,

notice that the organization is authorized by law to terminate or refuse to renew its contract with HCFA, that HCFA may also choose to terminate or refuse to renew its contact [sic] with the organization and that termination or nonrenewal may result in termination of the individual's enrollment in the organization.

(b) *Prohibited marketing activities – general.* In offering its plan to Medicare beneficiaries, an organization may not engage in any of the following practicies or activities:

(1) Practices that are discriminatory. For example, the organization may not engage in any activity intended to recruit Medicare beneficiaries from higher income areas (usually an indicator of better health) without making a comparable effort to enroll Medicare beneficiaries from lower income areas.

(2) Activities that could mislead or confuse Medicare beneficiaries, or misrepresent the organization, its marketing representatives, or HCFA. For example, the organization may not claim that it is recommended or endorsed by HCFA or that HCFA recommends that the beneficiary enroll in the organization. It may, however, explain that the entity is approved as an organization for purposes of participation in Medicare.

(3) Offers of gifts or payment as an inducement to enroll in the organization. This does not prohibit the explanation of any legitimate benefits the beneficiary might obtain as an enrolleee of the organization, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance or preventive services.

(4) Door-to-door solicitation of Medicare beneficiaries.

(5) Distriution of marketing materials if, before the expiration of the 45-day period described in paragraph(a)(3) of this section, the organization receives written notice from HCFA that HCFA has disapproved the material because it is inaccurate or misleading or it misrepresents the organization, its marketing reprentatives or HCFA.

* * *

California Business and Professional Code § 17200

§ 17200. Unfair competition; prohibited activities

As used in this chapter, unfair competition shall mean and include *any* unlawful, unfair or fraudulent business *act or* practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code.

(Amended by Stats.1992, c. 430 (S.B. 1586), § 2.)

* * *

California Business and Professional Code § 17203

§ 17203. Injunction; orders or judgments

Any person *who engages, has engaged, or proposes to engage in* unfair competition may be enjoined in any court

of competent jurisdiction. The court may make such orders or judgments, including the appointment of a receiver, as may be necessary to prevent the use or employment by any person of any practice which constitutes unfair competition, as defined in this chapter, or as may be necessary to restore to any person in interest any money or property, real or personal, which may have been acquired by means of such unfair competition.

(Amended by Stats.1992, c. 430 (S.B.1586), § 3.)

* * *

California Business and Profession Code § 17500

§ 17500. False or misleading statements

It is unlawful for any person, firm, corporation or association, or any employee thereof with intent directly or indirectly to dispose of real or personal property or to perform services, professional or otherwise, or anything of any nature whatsoever or to induce the public to enter into any obligation relating thereto, to make or disseminate or cause to be made or disseminated before the public in this state, or to make or disseminate or cause to be made or disseminated from this state before the public in any state, in any newspaper or other publication, or any adveritisng device, or by public outcry or proclamation, or in any other manner or means whatever, and statement, concerning such real or personal property or services, professional or otherwise, or concerning any circumstance or matter of fact connected with the proposed performance or disposition thereof, which is

untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading, or for any such person, firm, or corporation to so make or disseminate or cause to be so made or disseminated any such statement as part of a plan or scheme with the intent not to sell such personal property or services, professional or otherwise, so advertised at the price stated therein, or as so advertised. Any violation of the provisions of this section is a misdemeanor punishable by imprisonment in the county jail not exceeding six months, or by a fine not exceeding two thousand five hundred dollars ($2,500), or by both.

(Added by Stats.1941, c. 63, p. 727, § 1. Amended by Stats.1955 c.1358, p. 2443, § 1; Stats.1976, c. 1125, p. 5029, § 4; Stats.1979, c. 492, p. 1660, § 1.)

* * *

California Civil Code Section 1770

§ 1770. List of proscribed practices

The following unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or which results in the sale or lease of goods or services to any consumer are unlawful:

(a) Passing off goods or services as those of another.

(b) Misrepresenting the source, sponsorship, approval, or certification of goods or services.

(c) Misrepresenting the affiliation, connection, or association with, or certification by, another.

(d) Using deceptive representations or designations of geographic origin in connection with goods or services.

(e) Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have.

(f) Representing that goods are original or new if they have deteriorated unreasonably or are altered, reconditioned, reclaimed, used, or secondhand.

(g) Representing that goods or services are of a particular standard, quality, or grade, or that goods are of a particular style or model, if they are of another.

(h) Disparaging the goods, services, or business of another by false or misleading representation of fact.

(i) Advertising goods or services with intent not to sell them as advertised.

(j) Advertising goods or services with intent not to supply reasonably expectable demand, unless the advertisement discloses a limitation of quantity.

(k) Advertising furniture without clearly indicating that it is unassembled if such is the case.

(l) Advertising the price of unassembled furniture without clearly indicating the assembled price of such furniture if the same furniture is available assembled from the seller.

(m) Making false, or misleading statements of fact concerning reasons for, existence of, or amounts of price reductions.

(n) Representing that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law.

(o) Representing that a part, replacement, or repair service is needed when it is not.

(p) Representing that the subject of a transaction has been supplied in accordance with a previous representation when it has not.

(q) Representing that the consumer will receive a rebate, discount, or other economic benefit, if the earning of the benefit is contingent on an event to occur subsequent to the consummation of the transaction.

(r) Misrepresenting the authority of a salesperson, representative, or agent to negotiate the final terms of a transaction with a consumer.

(s) Inserting an unconscionable provision in the contract.

(t) Advertising that a product is being offered at a specific price plus a specific percentage of that price unless (1) the total price is set forth in the advertisement, which may include, but is not limited to, self tags, displays, and media advertising, in a size larger than any

other price in that advertisement, and (2) the specific price plus a specific percentage of that price represents a markup from the seller's costs or from the wholesale price of the product. This subdivision shall not apply to in-store advertising by businesses which are open only to members or cooperative organizations organized pursuant to Division 3 (commencing with Section 12000) of Title 1 of the Corporations Code when more than 50 percent of purchases are made at the specific price set forth in the advertisement.

(u) Selling or leasing goods in violation of Chapter 4 (commencing with Section 1797.8) of Title 1.7.

(v)(1) Disseminating an unsolicited prerecorded message by telephone without an unrecorded, natural voice first informing the person answering the telephone of the name of the caller or the organization being represented, and either the address or the telephone number of the caller, and without obtaining the consent of that person to listen to the prerecorded message.

(2) This subdivision does not apply to a message disseminated to a business associate, customer, or other person having an established relationship with the person or organization making the call, to a call for the purpose of collecting an existing obligation, or to any call generated at the request of the recipient.

* * *

California Civil Code § 1780

§ 1780. Consumer's action; relief; senior citizens or disabled persons; venue; court costs and attorney's fees

(a) Any consumer who suffers any damage as a result of the use or employment by any person of a method, act, or practice declared to be unlawful by Section 1770 may bring an action against such person to recover or obtain any of the following:

(1) Actual damages, but in no case shall the total award of damages in a class action be less than one thousand dollars ($1,000).

(2) An order enjoining such methods, acts, or practices.

(3) Restitution of property.

(4) Punitive damages.

(5) Any other relief which the court deems proper.

(b) Any consumer who is a senior citizen or a disabled person, as defined in subdivisions (f) and (g) of Section 1761, as part of an action under subdivision (a), may seek and be awarded, in addition to the remedies specified therein, up to five thousand dollars ($5,000) where the trier of fact (1) finds that the consumer has suffered substantial physical, emotional , or economic damage resulting from the defendant's conduct, (2) makes an affirmative finding in regard to one or more of the factors set forth in subdivision (b) of Section 3345, and (3) finds that an additional award is appropriate.

Judgment in a class action by senior citizens or disabled persons under Section 1781 may award each class member such an additional award where the trier of fact has made the foregoing findings.

(c) An action under subdivision (a) or (b) may be commenced in the county in which the person against whom it is brought resides, has his or her principal place of business, or is doing business, or in the county where the transaction or any substantial portion thereof occurred.

If within any such county there is a municipal or justice court, having jurisdiciton of the subject matter, established in the city and county or judicial district in which the person against whom the action is brought resides, has his or her principal place of business, or is doing business, or in which the transaction or any substantial portion thereof occurred, then such court is the proper court for the trial of such action. Otherwise, any municipal or justice court in such county having jurisdiction of the subject matter is the proper court for the trial thereof.

In any action subject to the provisions of this section, concurrently with the filing of the complaint, the plaintiff shall file an affidavit stating facts showing that the action has been commenced in a county or judicial district described in this section as a proper place for the trial of the action. If a plaintiff fails to file the affidavit required by this section, the court shall, upon its own motion or upon motion of any party, dismiss any such action without prejudice.

(d) The court shall award court costs and attorney's fees to a prevailing plaintiff in litigation filed pursuant to this section. Reasonable attorney's fees may be awarded to a prevailing defendant upon a finding by the court that the plaintiff's prosecution of the action was not in good faith.

(Amended by Stats.1988, c. 823, § 3; Stats.1988, c. 1343, § 2.)

* * *

LOGO

DEPARTMENT OF
HEALTH &
HUMAN SERVICES

DEC 20 1991

Health Care Financing
Administration

Office of Prepaid Health Care
Washington, D.C. 20201

Westcott W. Price III
President
FHP, Inc.
9900 Talbert Avenue
Fountain Valley, California 92708

Dear Mr. Price:

This letter is to notify you that, effective as of the date of this letter, we are closing the investigation of FHP, Inc. – California Region (FHP), which was initiated on July 1. This action is being taken pursuant to Section 1312 of the Public Health Service Act (the Act), as amended, and regulations at 42 CFR 417.163(b).

As stated in our July 1 letter to you, the purpose of the investigation was to determine whether FHP was in compliance with the requirements of the risk-based contract it holds with the Health Care Financing Administration (HCFA) under title XVIII of the Social Security Act. Specifically, HCFA was concerned that FHP might not be in compliance with the Federal requirements governing marketing activities as set forth at 42 CFR 417.428.

An on-site review was conducted during the week of July 15. That review concluded that while there were a number of anecdotal instances of improper sales practices being used by individual sales representatives, there was

no confirmation of systemic violations of Federal requirements, including no confirmed instances of door-to-door solicitation of Medicare beneficiaries. However, our review found that FHP did not have adequate processes in place to ensure that enrollment and disenrollment related problems were coordinated between FHP's sales, enrollment, claims, and appeals departments. Specifically, we did not find adequate systems to ensure (1) that Medicare beneficiaries were receiving the information necessary to make an informed decision about enrollment; and (2) that Medicare beneficiaries could cancel their enrollment when they change their minds before the effective date of enrollment.

Following the site visit, on August 23 we issued a letter to FHP setting forth the initial findings from our site visit, as well as our specific recommendations to address these findings. The August 23 letter required FHP to provide us a plan responding to the issues identified in our letter. On October 4, FHP submitted a comprehensive corrective action plan to address the concerns we had noted.

During the first week in November, HCFA conducted a follow-up site visit to assess the implementation of the corrective action plan. In our December 12 letter accepting the corrective action plan, we acknowledged that FHP had accepted all of the recommendations contained in our August 23 letter and had implemented revised policies and procedures in each of the areas to address the concerns we had previously raised. These improvements represent an aggressive response to the issues we had identified during our review.

As stated in previous discussions and letters, our decision to close the investigation would be based on an analysis of certain data indicators: beneficiary inquiries (including complaints) and disenrollments within 90 days of enrollment. We have now concluded our review of data that covers inquiries, and enrollment and disenrollment transactions for the period September through November; this analysis has confirmed a continuing and stable downward trend in the number of people choosing to disenroll within 90 days. In addition it has been noted that the content of beneficiary inquiries has altered significantly indicating that the corrective actions that FHP has taken have been effective in addressing our concerns.

Therefore, we are closing the investigation based upon a determination that FHP is in full compliance with Federal regulations governing Medicare risk-based contracting. As a result of closing the investigation, we will resume processing of the pending contract applications and requests for service area expansions. HCFA will continue to monitor FHP, as well as its competitors in the Southern California marketplace, to ensure continued compliance with Federal regulations.

Thank you again for the continued cooperation. Please contact Dorothea Musgrave, of my staff, with any questions you may have regarding this letter. She may be reached on (202) 619-0824.

Sincerely,

/s/ William F. Broglie
William F. Broglie
Director
Office of Prepaid Health Care
Operations and Oversight

cc: David Engleberg
Janet Newport
California Department of Corporations